DGA-PRODUCER PENSION AND HEALTH PLANS

spotlight on benefits

Volume 22, Number 2 | Summer 2014

Control Your Out-of-Pocket Costs: Submit Claims When They Are Incurred

If you send health claims directly to the Health Plan for reimbursement, you should submit those claims as soon as possible. If you wait to accumulate claims, you may find that the services you received were not considered medically necessary and not covered by the Health Plan.

Don't let claims accumulate. When you file claims directly with the Health Plan, you should submit your claims as soon as possible after the date of service. Timely filing will protect you from paying unexpected out-of-pocket costs when you receive medical services that may be deemed not medically necessary.

Timely filing is important because the Health Plan will not pay a claim for a service that is not medically necessary. The Health Plan regularly reviews claims for medical necessity. For example, physical therapy and outpatient mental health benefits are subject to review for medical necessity after 30 visits. At that time, the treating provider will be asked to provide proof of medical necessity before the Health Plan will pay any additional claims on your behalf for that category of service.

Let's say you submit 35 claims at one time for physical therapy appointments. Because more than 30 visits have been reached, the Health Plan will review all 35 claims for medical necessity. After the review is completed, you will be responsible for all costs associated with non-medically necessary claims. If you had submitted your claims on a timelier basis, the Health Plan would pay for the claims when received and send you a notice after 20 visits advising you that for claims over 30 visits you will be required to provide records to document medical necessity. Not only would the first 30 visits be covered, you could make an informed decision whether to continue the non-medically necessary treatment at your own cost.

It is important that you know the rules of your Health Plan. Submitting your claims as soon as possible after the date of service not only ensures timely processing, it also prevents unanticipated out-of-pocket costs. PH

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Free Preventive Care

Did you know the Health Plan offers certain preventive care services for free? That's right; the Plan covers 100% of the cost if certain services are performed in network.

Free Shingles Vaccine

The Health Plan covers the Shingles (Herpes Zoster) vaccine at 100% if you are age 60 or over, and you receive the vaccine at a network pharmacy or from a network doctor.

While the vaccine isn't typically recommended for people ages 50-59, you could still choose to receive the shingles vaccine with cost-sharing.

Childhood Immunizations and Screenings

In addition to the usual array of childhood immunizations that your child can receive for free, the Health Plan also provides free screenings. Any child under five can receive a free vision screening, and any child can get free hearing screenings.

Adult Screenings

There are other preventive care services for adults that are offered at 100% when using a network provider. These includes depression, obesity, blood pressure, and cholesterol screenings.

More Information

This article provides a brief overview of some of the preventive services offered by the Plan. Full coverage of some preventive services is subject to certain requirements such as age and/or gender.

For a full list of services and requirements, go to www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html. Any preventive care services as mandated by the ACA are offered at 100% of cost if you go to a network provider. PH

Stay Green and Save the Plans Money by Opting into E-Delivery

Next year, we will begin offering e-delivery of Plans documents, starting with our new Pension and Health Plans booklets due out in January. The Pension and Health Plan booklets are being rewritten to incorporate all changes since their last publication and to make them easier to read and understand.

Help make our office as green as possible and cut down on printing and postage costs by signing up for e-delivery. In addition to helping protect the environment, e-delivery helps make sure your documents are accessible whenever you need them.

Participants who opt in to e-delivery by November 1 will be automatically entered into a drawing to win a free iPad. On October 11 and 28, in-person e-delivery sign up will be offered at the DGA–PPHP Health Fairs.

Sign up is easy. To receive the booklets and other Plans documents via email and enter to win a free iPad, follow the simple instructions below:

1. Go to our secure webpage: https://docs.dgaplans.org/edelivery/
2. Enter your first name, last name, Plan ID (see below), and email address.
3. Click the check boxes to indicate that you choose to receive emails from DGA-PPHP, that you've read and understood the Privacy Policy, and that you are opting in for electronic delivery of Plans documents.
4. Click Subscribe.

That's it! Four easy steps to get you signed up for electronic delivery. PH

Where can I find my Plan ID?

Your Plan ID can be found on your Health Plan ID card. It is the eight digit number between the "DGA" and "J" on your card. If you don't have a Health Plan ID card, your Plan ID will be on your last Annual Pension Plans statement.

Have questions or problems with subscribing? Call our office at (323) 866-2200. PH

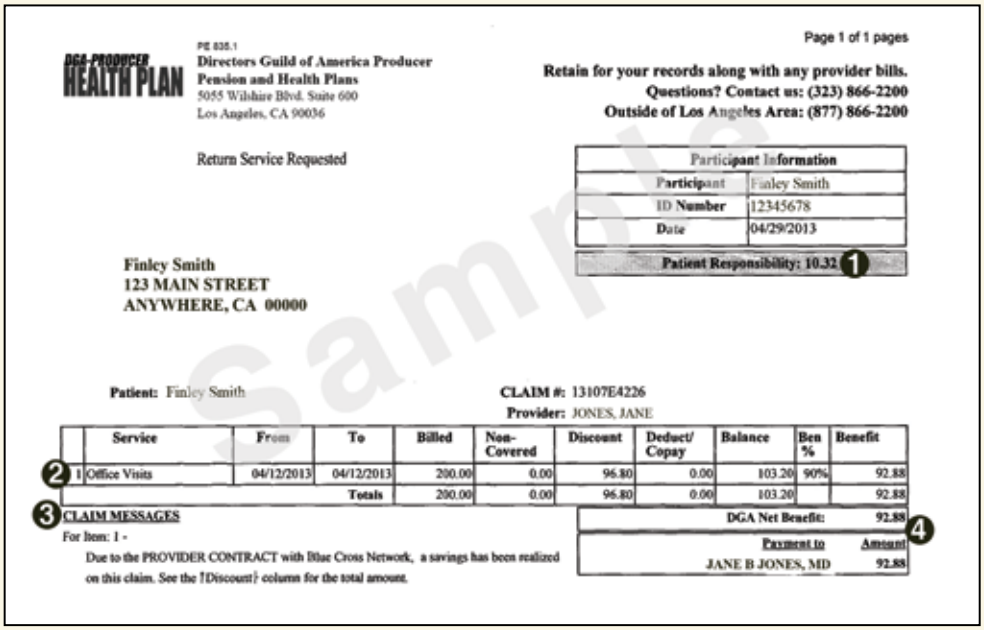
Being a Smarter Healthcare Consumer: Using Your Explanation of Benefits

How would you know if your doctor billed for only the services you received? Or if the Health Plan treated your doctor's charges as out of network instead of in network? If you aren't sure, the answer is in your mailbox.

After you go to the doctor, we will send you a statement of the doctor's charges. This statement is called the Explanation of Benefits, or EOB. EOBs provide information you can use to guard against billing errors and medical fraud and track your medical spending. Understanding them is an important part of staying informed about your healthcare expenses.

How to Read Your EOBs

The sample below gives an overview of the most important sections of your EOB.



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Retain for your records along with any provider bills.
Questions? Contact us: (323) 866-2200
Outside of Los Angeles Area: (877) 866-2200

Return Service Requested

Participant Information	
Participant	Finley Smith
ID Number	12345678
Date	04/29/2013
Patient Responsibility: 10.32 (1)	

Finley Smith
123 MAIN STREET
ANYWHERE, CA 00000

Patient: Finley Smith
CLAIM #: 13107E4226
Provider: JONES, JANE

	Service	From	To	Billed	Non-Covered	Discount	Deduct/ Copay	Balance	Ben %	Benefit
(2) 1	Office Visits	04/12/2013	04/12/2013	200.00	0.00	96.80	0.00	103.20	90%	92.88
			Totals	200.00	0.00	96.80	0.00	103.20		92.88

(3) CLAIM MESSAGES
For Item: 1 -
Due to the PROVIDER CONTRACT with Blue Cross Network, a savings has been realized on this claim. See the 'Discount' column for the total amount.

DGA Net Benefit: 92.88 (4)

Payment to	Amount
JANE B JONES, MD	92.88

Sample

1. **Patient Responsibility:** This is the amount you pay out-of-pocket.

2. **Claim/Benefits Information:** This section includes details about your claim and how your benefits were applied:

   - **Service:** a description of the service you received
   - **From/To:** the dates that service was provided
   - **Billed:** the amount billed by the provider
   - **Non-Covered:** the amount of the billed charges that is not covered by the Health Plan, such as any amount over the Reasonable and Customary charge for a non-network service
   - **Discount:** the discount applied for using a network provider
   - **Deduct/Copay:** the portion of the billed amount that you are responsible for either as your copay or deductible
   - **Balance:** the remaining billed charges after all deductions
   - **Ben%:** the co-insurance percentage applied to the balance. This percentage varies based on whether it is network or non-network.
   - **Benefit:** the dollar amount that the Health Plan paid

3. **Claims Messages:** This section lists special messages from the Health Plan. Each message will reference a specific line of the EOB. These messages could include information about discounts applied (as in the sample), requests for additional information, explanations for why an item was not covered, etc.

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4 **Total Benefit/Payment Information:** This section tells you the total dollar amount the Health Plan paid and where payment was sent.

How to Use Your EOBs

You can use your EOBs for a number of purposes:

Anticipate your bill. The bill you receive from your doctor should never be higher than the Patient Responsibility amount on your EOB.

Track your medical spending. EOBs are an easy way to track how much you have paid toward your annual deductible or to keep a tally of your medical expenditures for the year. Both can be helpful for budgeting for out-of-pocket costs or completing tax forms.

Verify accuracy of billing. You should always check your EOBs for accuracy. EOBs are a key tool in our efforts to fight medical billing fraud, such as intentional over billing, claims from providers you did not visit, etc.

Some questions you should ask:

- Is the service listed accurately? For example, you should not be charged for a surgery when all you had was an office visit.
- Is the Health Plan sending payment to the correct party? Most claims are paid to the provider, but if you paid in full at the time of service, payment will most likely be made directly to you.
- Were your benefits applied correctly? If they were applied differently than what you expected, call us. Our Participant Services Representatives will be happy to assist you.

Being a smarter healthcare consumer means monitoring how your benefits get applied. Careful reading of your EOBs is a key part of that process. To be sure that you are not being overcharged, you can match the EOB with your bill BEFORE submitting payment to your provider. This can help you catch any errors before you send payment. If you have questions about an EOB, give us a call at (323) 866-2200 ext. 401. PH

Notice to HealthNet HMO Participants

Effective **January 1, 2015**, the Health Plan will no longer offer the HealthNet HMO Plan. If you elect the HMO, you will be moved to the corresponding (Premier or Choice) PPO Plan on January 1, 2015.

If you have questions about the change, please contact the Health Plan at (877) 866-2200, Ext. 402. PH

Spotlight on Benefits

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Spotlight on Benefits is published up to four times a year for the benefit of Pension and Health 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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DGA-PPHP Health Fair

On **Saturday, October 11**, the DGA–Producer Pension & Health Plans will be hosting a Health Fair from 9:00 a.m. to 12:00 p.m. in the lobby of the DGA's Los Angeles office at 7920 Sunset Boulevard. Come join us for:

- **Free Flu Shots** (reservation required; RSVP to flushots@dgaplans.org to guarantee a free flu shot or call (323) 866-2216.) If you are not currently covered by the Health Plan, the DGA Foundation will cover the cost for you and your family members.
- An **Actors Fund** seminar on signing up for health insurance through the Covered California Health Insurance Marketplace.
- A **Pension and Health Seminar** conducted by our staff.
- A **Raffle** to win a brand new iPad mini and other prizes.
- **Free Neck and Back Massages** available on-site on a first-come, first-served basis.

Register for e-delivery of all Plans documents and be entered in a special drawing to win an iPad.

All members (not just current Health Plan participants) are encouraged to attend the fair. PH

Free Flu Shots

Los Angeles

On **Saturday, October 11**, free flu shots will be offered at the DGA–PPHP Health Fair in Los Angeles, CA.

On **Tuesday, October 28**, free flu shots will be offered from 5:00 p.m. to 6:30 p.m. at the UCLA-MPTF Toluca Lake Center located at 4323 Riverside Drive in Burbank, CA.

New York City

On **Monday, November 10**, there will be a free flu shot clinic from 5:00 p.m. to 6:30 p.m. at the DGA's New York office at 110 West 57th Street, 6th Floor (between Avenue of the Americas & 7th Avenue).

Flu shots are free for both Health Plan participants and non-covered members, including dependents age 13 and over. The DGA Foundation will cover the cost for DGA members and their families not covered under the Health Plan.

Women who are pregnant or nursing cannot be given the flu shots and should check with their OB-GYN for more information.

You must RSVP to flushots@dgaplans.org or call at (323) 866-2216 to guarantee a free flu shot for any of these events. PH