SUMMER 2016

Spotlight on Benefits is published up to four times a year for participants in the DGA–Producer Pension and Health Plans.

HOW YOUR MENTAL HEALTH AND PHYSICAL THERAPY BENEFITS WORK

All care covered under the Health Plan must be considered medically necessary. Find out how this standard gets applied to claims for mental health and physical therapy.

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DGA-PRODUCER PENSION & HEALTH

Spotlight ON BENEFITS

Effective Immediately, a New Process for Submitting Medical Claims

In January 2013, the DGA–Producer Health Plan began transitioning a number of claims-related functions to Blue Cross as part of a new contract aimed at leveraging Blue Cross' organizational structure to ensure correct pricing, conserve Plan resources and control administrative costs. The Health Plan's contract with Blue Cross requires that all medical claims be submitted directly to Blue Cross.

Effective immediately, medical claims should not be sent to the Health Plan office. All medical claims should be sent directly to the local Blue Cross office in the state where services were received. Medical claims for services received outside the United States should now be sent to the BlueCard Worldwide Service Center in Miami, Florida. The table on page 5 summarizes the changes in the medical claims submission process.

These changes affect medical claims only. Dental, prescription and vision claim submissions are not affected. Be sure to note that, depending on where services were received, certain medical claims may now be submitted to Blue Cross via fax or email. PH

Spotlight
ON BENEFITS

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DGA-PRODUCER
PENSION & HEALTH

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Los Angeles, CA 90036

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ABOUT THE PLANS

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 Directors Guild of America and are administered by a Board of Trustees made up of DGA representatives and Producers' representatives.

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Avoid Unexpected Out-of-Pocket Costs. Send Claims As They Are Incurred.

Letting your non-network medical claims accumulate before submitting them can cost you.

Though the Health Plan allows up to one year from the date of service to file non-network claims, waiting to submit in bulk can lead to unexpected (and considerable) costs if the services you received are deemed not medically necessary.

All medical claims are evaluated for medical necessity as they are received. Only services deemed medically necessary are covered under the Health Plan.

Filing claims as they are incurred ensures you know at the earliest opportunity if a particular service is not covered under the Health Plan. You can then decide accordingly whether to continue that service (and pay out of pocket) or seek alternative treatments.

This is especially true for services that typically require multiple visits, like mental health or physical therapy. (Read *How Your Mental Health and Physical Therapy Benefits Work* on page 3 for more information on mental health and physical therapy benefits.)

Let's say you visit a physical therapist once a week for 35 weeks. Instead of filing each claim as it was incurred, you file all 35 claims in bulk at the end of the year. Physical therapy claims are subject to review for medical necessity after 30 visits. By filing all 35 claims at once, the evaluation for medical necessity, which would have taken place after 30 visits, would occur when the bulk claims are received. If, upon evaluation, treatment is found to be not medically necessary, you would be fully responsible for the charges on all 35 claims.

If the claims had been filed timely, the results of the evaluation for medical necessity would have been known sooner, allowing you to decide how and whether to proceed before incurring additional out-of-pocket costs.

Submitting your claims as soon as possible after they are incurred ensures timely processing and helps prevent unanticipated out-of-pocket expenses. PH

Have a new email, mailing address or phone number? Don't forget to tell us!

Every year, directors and beneficiaries become eligible for health or pension benefits with the DGA–Producer Pension and Health Plans, but some are unaware of it because the Plans office cannot immediately locate them due to outdated information. Don't let this be you.

The Address Change Department at the Plans' office has expanded its capabilities to make updating your information easy and convenient. To submit an update, complete a Change of Address Form (available at dgaplans.org/forms.htm), and return it using the information at the far right. You can also speak to an Address Change Representative at (323) 866-2200 ext. 407, Monday through Friday, 8:30 a.m. to 5:00 p.m. Pacific Time, or you can leave a voicemail message for them at any time.

When updating your information with the Plans' office, be sure to also update the Directors Guild of America, Inc. at (310) 289-2000, as the two are separate entities.

Don't let yourself or your beneficiaries miss out on valuable benefits to which you might be entitled. Always keep your contact information current with the Plans' office to ensure we can find you when needed. PH

Return your completed Change of Address Form by fax, email or mail.

Fax to:
(323) 866-2389

Email to:
addresschange@dgaplans.org

Mail to:
DGA-Producer Pension and Health Plans
5055 Wilshire Blvd
Suite 600
Los Angeles, CA 90036

How Your Mental Health and Physical Therapy Benefits Work

All care covered under the Health Plan must be considered medically necessary, and for most doctor visits, meeting this standard is straightforward. With other services, however, such as mental health or physical therapy, which typically require ongoing, regular visits, applying the Medically Necessary standard is not as simple. If you or your dependents use these benefits, you should understand how the Health Plan covers these services.

Though mental health and physical therapy services are covered for unlimited visits when treatment is medically necessary, the more extended nature of these services means that the determination of medical necessity must take place at intervals throughout the ongoing treatment. This process ensures that treatment is both effective for the patient and an appropriate expenditure of the Health Plan.

The Health Plan considers physical therapy medically necessary only when such care is prescribed by a physician, chiropractor, podiatrist or other health professional qualified to prescribe physical therapy in order to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, injury or surgical procedure over a clearly defined period of time. Physical therapy is medically unnecessary if:

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Therapy Benefits

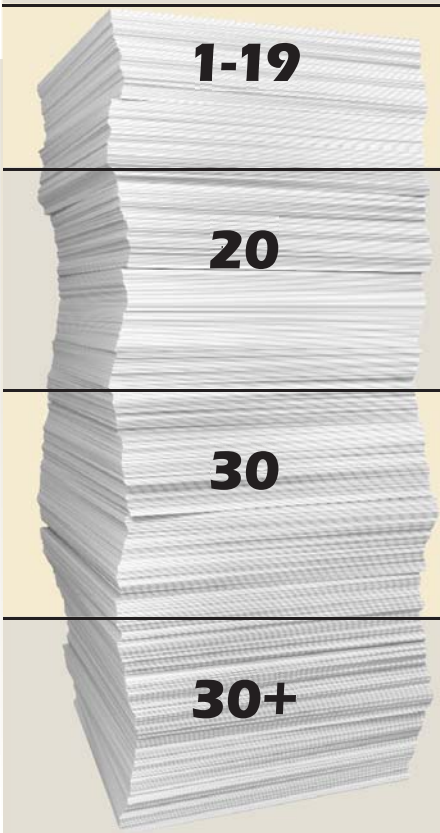
- Therapeutic benefit has been achieved, or a home exercise program could be used for further gains;
- The patient is asymptomatic or has no identifiable clinical condition;
- The patient's condition is stable (*i.e.* not getting worse and not improving).
- Continued physical therapy is past the time period specified in the initial treatment plan without re-evaluation by a referring provider.

Maintenance programs are always considered not medically necessary. A maintenance program consists of treatments or activities that preserve the individual's present level range, strength, coordination, balance, pain, activity, function, etc. and prevent regression of the same parameters. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. In certain circumstances, the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program, however, the repetitive physical therapy services to maintain a level would be considered not medically necessary.

Mental health and physical therapy claims are evaluated for medical necessity after 30 visits. If claims are filed timely, after 20 visits, the Health Plan notifies the participant and provider(s) that records will be required after 30 visits to ensure medical necessity. The table at the bottom of this page explains how this works.

Filing claims as they are incurred keeps you aware of where you are in the process, so that you can make an informed decision on how to proceed. (Refer to *Avoid Unexpected Out-of-Pocket Costs. Send Claims As They Are Incurred.* on page 2.)

For more information on medical necessity, refer to pages 113–114 of the March 2015 Health Plan Booklet, available at dgaplans.org/forms.htm. **PH**

Number of Claims	What To Expect
	If claims have been filed timely and all other requirements for Plan coverage and medical necessity are met, these visits would normally be covered.
20	After the Health Plan receives the claim for the 20th visit, the Health Plan sends you and your doctor a notice advising that, at 30 visits, the doctor must provide records to show the medical necessity of continued treatment. At this point, the Health Plan continues covering treatment.
30	After the Health Plan receives the claim for the 30th visit, the Health Plan sends you and your doctor a notice requiring that the doctor submit records to show continued treatment is medically necessary. Health Plan coverage of further treatment is suspended, pending review of the requested records.
30+	Claims received after the 30th visit are placed on hold pending the review for medical necessity. Failure to provide the required information will result in automatic denial of these claims. The results of the evaluation for medical necessity will determine whether these and subsequent visits will be covered, and at what interval additional medical necessity reviews will be required.

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New Claims Submission Process

Where Services Were Received	What's New

In California

- Submit medical claims directly to Blue Cross
  - ◊ **By fax**: (choose one) **RECOMMENDED**

    (866) 896-1393 (866) 896-6531

    (866) 896-6626 (866) 896-6532

    When submitting claims by fax, be sure to keep the fax confirmation page for your records.

    NOTE: If you have Caller ID Block on your number, you will need to temporarily disable the feature by dialing *82 before faxing your claims to Blue Cross.
  - ◊ **By mail**:

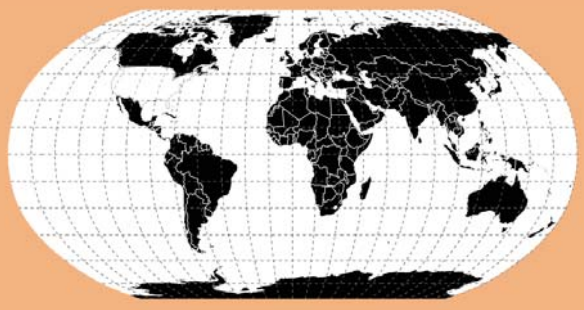
    Anthem Blue Cross
    PO Box 60007
    Los Angeles, CA 90060

In the United States (outside CA)

- **Mail your medical claims directly to the local Blue Cross office** for the state where services were received.

  For Blue Cross office addresses by state, go to www.dgaplans.org/filingaclaimNonCA.htm

Outside the United States, Puerto Rico and US Virgin Islands



- You must submit a BlueCard Worldwide International Claim Form (with or without an itemized bill).

  The form is available at www.dgaplans.org/forms.htm.
- Submit medical claims directly to Blue Cross
  - ◊ **By email:** (**RECOMMENDED**):

    claims@bluecardworldwide.com
  - ◊ **By mail**:

    BlueCard Worldwide Service Center
    PO Box 261630
    Miami, FL 33126
    USA

For complete step-by-step instructions on submitting your claims, visit www.dgaplans.org/filingaclaim.htm.

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Visit Us Online
www.dgaplans.org

Health Fairs this Fall in LA & NYC

The DGA–Producer Pension and Health Plans will be hosting health fairs and free flu shot clinics exclusively for DGA members and their families in Los Angeles and New York City this fall. Save the date for the event nearest you:

Los Angeles

October 1
9:00 a.m. to 12:00 noon
(Flu shots until 1:00 p.m.)
DGA Lobby
7920 Sunset Boulevard

New York City

October 22
2:00 p.m. to 5:00 p.m.
DGA New York Theater Lobby
110 West 57th Street

DGA members, Pension and Health Plans' participants and family members are welcomed to join us for:

- **Free Flu Shots. Reservations required. RSVP to FluShots@dgaplans.org or at (323) 866-2216.** Flu shots are available to all DGA members and their dependents age 13 and over. Women who are pregnant or nursing cannot be given the flu shots and should check with their OB-GYN for more information. The DGA Foundation is covering the cost of flu shots for participants not covered under the Health Plan.
- **Benefits Information.** The Pension and Health Plans' staff, along with representatives from Express Scripts, Delta Dental, and Vision Service Plan, will be onsite to provide information on the diverse benefits available to participants and DGA members.
- **Actors Fund Seminar.** For those not covered by the Health Plan, a presentation will be given on the state's Health Insurance Marketplace.
- **Free neck and shoulder massages**
- **Raffle prizes and giveaways**, including a chance to win a new Fitbit!

In Los Angeles only:

- **More Benefits Information.** Presentations will be given by DGA-Producer Pension & Health Plans' staff on the diverse set of benefits available to DGA members and representatives from UCLA Health/MPTF will be onsite to answer questions.

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