

Spotlight

ON BENEFITS

SUMMER 2021

Welcome ♥ CVS caremark®!

Effective July 1, the Health Plan completed its transition to CVS Caremark as its prescription drug benefit manager. All existing prescriptions and coverage were automatically transferred to CVS Caremark during the transition.

By now, you should have received your CVS Caremark Welcome Kit, which includes your new prescription card. You should begin using the card to fill your prescriptions. If you have not received your Welcome Kit, you can request one by calling CVS Caremark at (855) 271-6601. You can also register on caremark.com or the CVS Caremark mobile app to access a copy of your prescription card and make managing your prescriptions easier. Registration takes just a few minutes, can be completed with or without your prescription card, and provides access to an assortment of tools to make managing your prescriptions easier.

While the transition to CVS Caremark will be seamless for the majority of Health Plan participants, if you meet any of the following criteria, you may need to take additional steps to ensure continuous access to your prescriptions:

- ☐ **If you had mail order prescriptions with refills remaining before the transition to CVS Caremark**, you will need to login to caremark.com or call (855) 271-6601 to provide your mail order payment information. For your security, this information was not included in the transfer of information.
- ☐ **If you take a specialty medication and you have not already spoken to CVS Specialty**, you should

contact CVS Specialty at (800) 237-2767, Monday through Friday, 6:30 a.m. to 8:00 p.m. Central Time to complete your account set up.

- ☐ **If you take a medication that is not covered under CVS' formulary, your medication will continue to be covered until October 1. This will allow you time to contact your doctor and discuss covered alternatives.** At the end of July, CVS Caremark will send you a letter notifying you if your drug is not covered and ask that you discuss the change with your doctor. After October 1, if you continue to fill prescriptions for the same drug, you will have to pay the entire cost of the medication.
- ☐ **If you have in place prior authorizations that extend beyond July 1, CVS Caremark will honor the prior authorizations through the original expiration date.**

New Prescription Drug Benefits Coming September 1

In addition, CVS Caremark brings three new programs to the Health Plan's prescription drug benefit, starting September 1. PrudentRx, AccordantCare and Health Advisor will offer eligible participants significant savings on certain prescription drug costs and will provide personalized support for managing complex and rare conditions...**at no additional cost.** Eligibility requirements and enrollment procedures for each program are described inside this issue, beginning on page 2. **PH**

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Beneficiaries Are?
(Are You Sure?)
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Spotlight

ON BENEFITS

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DGA-PRODUCER PENSION & HEALTH

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

STARTING

September

1

**PrudentRx**

\$0 out-of-pocket
cost for specialty
medications

Specialty medications are used to treat chronic or rare conditions or are medications that might require special handling, administration or preparation. Because of their complexity, specialty medications are among the most expensive prescription drugs available. In 2020, specialty drugs represented over 60% of the Health Plan's total prescription drug spend at a cost of more than \$17 million. The PrudentRx program, available September 1, will reduce your co-pay to \$0 and save money for the Health Plan, freeing valuable resources to maintain the Plans' robust benefits.

To find out if you are currently taking a specialty medication, check www.CVSSpecialty.com/druglist. All participants who take specialty medications will be automatically enrolled in PrudentRx and may opt out at any time by calling (800) 578-4403. However, **if you opt out of PrudentRx, you will pay 30% co-insurance on all specialty medications filled through CVS Specialty.**

How it Works

PrudentRx works with drug manufacturers on your behalf to enroll you in manufacturers' co-payment assistance programs if one is available for your

**If you opt out of
PrudentRx,
you will pay 30%
co-insurance on all
specialty medications
filled through
CVS Specialty.**

medication. For as long as you take part, PrudentRx will also manage your renewals for those co-payment assistance programs. When such a program is not available or when your eligibility for a manufacturer's assistance program expires, your out-of-pocket costs will remain at \$0 for your specialty medication as long as you are enrolled in the PrudentRx program.

PrudentRx works closely with CVS Specialty to ensure all applicable savings are applied to your specialty medications before they are delivered. Specialty prescriptions filled at any pharmacy other than CVS Specialty will not be eligible for PrudentRx savings and you will pay the full cost.

How to Enroll

Enrollment in PrudentRx is automatic for all covered Health Plan participants who are taking specialty medications. Enrolled participants will receive a welcome letter and phone call from PrudentRx to answer any questions they might have. Because each manufacturer of specialty medications may have its own co-payment assistance programs, whenever you add or change a specialty medication, PrudentRx may need to contact you to enroll you in the new medication's assistance program. PrudentRx Member Advocates are available for questions and assistance Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Time, at (800) 578-4403.

Some manufacturers may require additional information to complete your enrollment in their co-payment assistance programs. In these cases, you will be contacted by PrudentRx. Additionally, to provide you with sufficient time to supply the necessary information and to complete your PrudentRx enrollment, the Health Plan will allow a one-time only "courtesy fill" of your specialty medication without cost-sharing after September 1, 2021. **PH**



PrudentRx

- ▶ You pay \$0 out of pocket for your specialty medications for as long as you remain in the program.
- ▶ Participants on specialty medications are automatically enrolled.



If you opt out...

You will pay 30% co-insurance for your specialty medications.

STARTING
September
1



CVS Health
Advisor

Individualized support that
changes with your needs



Managing a chronic condition can be a challenge, especially over time as your life changes.

Health Advisor supports you through those changes by making sure you stay on track with all aspects of your health-care. Health Advisor takes into account your circumstances at any given time to keep you informed of the next best actions you should take, not only regarding your chronic condition, but for your continued overall health and wellness. Health Advisor's interventions might be as simple as an email suggesting you get a vaccination or as involved as a one-on-one counseling session with a CVS pharmacist—all designed to complement your existing care management.

How it Works

Health Advisor continuously reviews information from a variety of sources—prescription claims, medical visits and the like—to develop a comprehensive picture of where you are in managing your chronic condition and determine your

next best actions. Depending on your circumstances, Health Advisor's messaging might come via any of several channels, including telephone, direct mail, email, SMS text, prescription bag messages, messages through your provider and/or face-to-face pharmacist consultations. You are not obligated to do anything in response to these messages. You and your doctor can decide what actions, if any, you will take.

How to Enroll

All covered Health Plan participants are automatically enrolled in Health Advisor, as it provides care coordination to help participants improve their health outcomes and reduce costs. You may opt out of receiving communications from Health Advisor by calling (855) 271-6601. **PH**



Accordant[®]

♥CVS specialty™ nurse care management

Multi-disciplinary support for complex needs

STARTING

September

1

The AccordantCare program offers health management support to participants with any of 19 different rare or chronic conditions by providing access to its collection of case management tools to complement your providers' care. The AccordantCare program has been shown to be associated with better health, lower costs and fewer hospital readmissions for individuals with complex conditions. Enrollees can choose from two levels of engagement so that they participate in the program as much or as little as they like.

19 Conditions served by AccordantCare

- ▶ Amyotrophic Lateral Sclerosis (ALS)
- ▶ Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- ▶ Crohn's Disease
- ▶ Cystic Fibrosis
- ▶ Dermatomyositis
- ▶ Epilepsy (Seizures)
- ▶ Gaucher Disease
- ▶ Hemophilia
- ▶ Hereditary Angioedema
- ▶ Human Immunodeficiency Virus (HIV)
- ▶ Multiple Sclerosis
- ▶ Myasthenia Gravis
- ▶ Parkinson's Disease
- ▶ Polymyositis
- ▶ Rheumatoid Arthritis
- ▶ Scleroderma
- ▶ Sickle Cell Disease
- ▶ Systemic Lupus Erythematosus (SLE or Lupus)
- ▶ Ulcerative Colitis

How it Works

The AccordantCare program offers an array of health management tools to support those with complex conditions. Enrollment is voluntary, with participants choosing from two levels of engagement:

- ▶ **Interactive** participants are assigned a dedicated RN who contacts them at least quarterly (more frequently as needed) to complete a risk assessment.
- ▶ **Self-directed** participants receive the same benefits as interactive members, except they have opted not to have a nurse contact them on a regular basis.

The services available at each level are described below:

AccordantCare-Available support services	Interactive Level	Self-directed level
▶ Routine health risk assessments conducted by an RN to identify risk factors, gaps in care and opportunities for optimal self-management	✓	✗
▶ 24/7 access to a dedicated registered nurse (RN) who specializes in your particular condition and provides ongoing support and education, including help with managing multiple, coexisting conditions	✓	✓
▶ Personalized education and monitoring based on individual needs, including specialized support for your health goals	✓	✓
▶ Monthly newsletters focusing on condition-specific self-management strategies	✓	✓
▶ Targeted educational mailings triggered by claims-based gaps in care and adverse events	✓	✓
▶ A wide range of online resources, including educational materials and interactive forums, available at www.Accordant.com/DGA-PHP	✓	✓
▶ Physician notification of program enrollment and ongoing collaboration with your primary care provider on your plan of care	✓	✓
▶ Help finding resources that provide psychosocial support, end-of-life counseling and caregiver assistance	✓	✓
▶ Case management and coordination of care	✓	✓



#1 REASON FOR DENIED CLAIMS: No Current Coordination of Benefits Form

These services offer support to enrollees as needed—whether that means talking through symptoms you might be experiencing, managing potential prescription drug interactions, coordinating transportation assistance or organizing caregiver support—all to keep you in optimal health throughout the course of your condition.

As part of enrolling in AccordantCare, you will also be given access to the MyChart website and Condition Advisor mobile app (pictured at right), both of which allow you to easily and securely contact your assigned care team any time day or night, track symptoms, view and manage any care plan that you and your nurse create and use the AccordantCare health library to find helpful information specific to your condition.



CONDITION ADVISOR MOBILE APP
AccordantCare enrollees gain access to the MyChart website and Condition Advisor mobile app, which come with a number of useful features to help you stay on track with managing your chronic condition.

How to Enroll

You must opt in to the AccordantCare program. If you are identified as having any of the 19 conditions serviced by the program, AccordantCare will send you a welcome letter, informational brochure and new member form with which you can begin your enrollment, if you choose. AccordantCare may also contact you by phone. For more information about the program or to enroll, you may also call AccordantCare at (800) 237-6507. **PH**

You must submit an updated Coordination of Benefits Form any time you or your dependents have coverage with another health plan and at least once every 12 months during which you are covered under the Health Plan, even if your information has not changed.

Every year you are eligible for benefits under the DGA—Producer Health Plan, you receive an open enrollment packet with information about your coverage, as well as documents the Health Plan needs to accurately process claims for you and your dependents. One of those documents is called the Coordination of Benefits Form, which is used by the Health Plan to determine if you have health coverage with other insurers so that your claims are processed appropriately.

The Health Plan requires that you update your Coordination of Benefits information any time you or your dependents add or drop coverage with another health plan and at least once every 12 months during which you have Health Plan coverage, even if the information has not changed. **Without a current Coordination of Benefits Form, your claims will be denied.**

The number one reason claims are denied is because there is no current Coordination of Benefits Form on file.

Though claims denied for this reason can be reprocessed once you submit an updated Coordination of Benefits Form, it is easier to avoid the hassle if you can. Returning your Coordination of Benefits Form as soon as possible after you receive your open enrollment packet will help you avoid your and your dependents' claims being denied.

For more information about coordination of benefits, refer to our Coordination of Benefits FAQs at www.dgaplans.org/COB. You can download a copy of the Coordination of Benefits Form at www.dgaplans.org, or you can call the Health Plan at (323) 866-2200, Ext. 401, to request a copy be mailed to you at no cost. **PH**

Do You Know Who Your Beneficiaries Are?



(Are You Sure?)

Every year, we take important actions to stay on track and stay safe: we change our clocks; we check the smoke alarms; and we do our taxes. Yet, another and often overlooked item you should also maintain is your Beneficiary Designation Form with the Plans.

One of the most costly retirement and estate planning errors that participants make is failing to keep their Beneficiary Designation Form updated. Each year, the Plans office hears from a surviving family member or loved one surprised to find an ex-spouse or deceased relative unintentionally left as the beneficiary of a deceased participant's survivor benefits. For example, the classic worst-case scenario is you get divorced, but your ex-spouse remains as your beneficiary because you never changed the form. You might have changed your will to reflect your current wishes, but **after you die, it is your Beneficiary Designation Form (and not your will) that determines who receives survivor benefits.**

Beneficiary Designation Forms override last wills and testaments in court, so those with assets to pass on should update them regularly, particularly after major life events like marriages, divorces, births and deaths.

You can quickly and easily check your current beneficiaries at any time using the **myPHP** online benefits portal, available at www.dgaplans.org/myPHP. Registered **myPHP** users can view a listing of their current beneficiaries for the Basic and Supplemental Pension Plans, as well as the amount or percentage allotted to each, on the Pension tab (pictured at right). The Beneficiary Designation Form is available on **myPHP** for you to download, complete and submit to the Plans office.

Having No Beneficiaries is Just as Bad

Just as problematic as having an outdated Beneficiary Designation Form is not having one at all. Your Beneficiary Designation Form is as important as your will and other documents and should be considered integral to

your estate planning. Because of the complexity of laws governing estate issues, it is advisable that you consult an estate planner to make sure that your wishes are reflected in the appropriate documents.

In addition to the Beneficiary Designation Form, it is important to regularly review and update your HIPAA Authorization Form, Adult Dependent Authorization Form, and Third-Party Authorization Form, if you have any on file. These authorizations give the Plans office permission to discuss certain information with the people you designate. As those individuals change, so should your authorization forms.

To conclude, keeping your Beneficiary Designation Form up to date is just as important as doing your taxes or checking your smoke alarms. Set a time each year (such as tax season) to review your Beneficiary Designation Form and be sure to update it whenever your circumstances change. The Beneficiary Designation Form, as well as other important Pension and Health Plans forms, are available on the **myPHP** online benefits portal in the Documents and Forms tab and online at www.dgaplans.org/forms.

Similarly, you should make sure that your contact information on file with the Plans is current and accurate, and notify us of any changes so we can keep you informed regarding your benefits. **PH**

Check your beneficiaries on the **myPHP** online benefits portal

Log into your **myPHP** online benefits portal account and click the Pension tab for a list of your current beneficiaries. To create your free portal account, have your Plan ID number ready, and go to www.dgaplans.org/myPHP.

Working After Retirement?

Be Sure You Know the Basic Plan's Suspension of Benefits Rules.

After you begin receiving a monthly pension benefit from the Basic Plan, it is not uncommon that at some point during your “retirement” you may work again. Under certain circumstances, however, continued work after your benefits commence may lead to your monthly Basic Plan benefit being suspended. This is called Suspendible Service, and it is an important part of financial planning.

Suspendible service is defined as employment in the same industry, in the same trade or craft worked under Covered Employment, and in the same geographic area covered by the Plan. For example, if you worked as a 1st Assistant Director at all times prior to your retirement from the Basic Plan, any work as a 1st Assistant Director after retirement would be considered Suspendible Service. However, work as a Director after retirement would not be considered Suspendible Service.

Suspendible service rules only apply to work performed before your Required

Beginning Date. Your Required Beginning Date is April 1 in the calendar year after you turn 72. For example, if you turn 72 on December 31, 2021, your Required Beginning Date is April 1, 2022.

If you receive a monthly Basic Plan benefit and work in Suspendible Service

month, your Basic Plan benefit will be suspended for that month.

If you are receiving a monthly Basic Plan benefit, you must notify the Plans office, in writing, within 21 days upon starting employment that is considered Suspendible Service. You can do this by filling out and returning the Employment Recap Form available at www.dgaplans.org/forms/pension. If you do not notify the Plans office, and it is later determined that your benefits should have been suspended, the overpayments will be recovered from your future benefit payments.

Likewise, you should also notify the Plans office when you have stopped performing Suspendible Service. Once notified, your benefits will begin again in the month after the last month during which benefits were suspended.

For full details on Suspendible Service, refer to the March 2020 Pension Plans Summary Plan Description and its updates. If you have further questions, contact a Pension Department representative by phone at (323) 866-2200, Ext. 404, or email pension@dgaplans.org. **PH**

EMPLOYMENT RECAP FORM

PH PRODUCER PENSION & HEALTH

EMPLOYMENT RECAP FORM

You must complete and return this form to the Directors Guild of America—Producer Pension Plans office if you have performed Suspendible Service (refer to page 24 of the March 2020 Pension Plans Summary Plan Description for details). You can return this form via the **PH** online benefits portal (To register, have your Plan ID number ready and visit dgaplans.org/myPHP), mail to DGA—Producer Pension Plans, 5055 Wilshire Blvd, Ste. 600, Los Angeles, CA 90036, fax to (323) 653-3560 or email to pension@dgaplans.org.

Participant Name: _____ Plan ID: _____

If you have returned to work, provide a recap of your recently completed employment:

Year	Month	Job Category	Number of Days Worked	Name of Employer
	January			

EMPLOYMENT RECAP FORM. If you have not reached your Required Beginning Date and you receive a monthly Basic Plan benefit, you must submit an Employment Recap Form whenever you perform Suspendible Service.

before your Required Beginning Date, the following Suspension of Benefits rules apply:

- ▶ If you work seven days or fewer of Suspendible Service in a calendar month, you will continue to receive your monthly Basic Plan benefit.
- ▶ If you work eight or more days of Suspendible Service in a calendar



Don't Wait to Submit Your Non-Network Claims to Anthem

Get instant confirmation when you submit non-network claims online at www.anthem.com.

Despite the time and financial savings you get from using Anthem Blue Cross network providers, there are circumstances in which you may choose to use services or providers outside the network. If you incur a non-network medical claim, you will likely have to submit the claim yourself. To help ensure your claim gets processed timely, be sure to follow the three simple tips below.

1 Submit claims online at www.anthem.com ...NOT myPHP.

The easiest and quickest method to submit your non-network claims is online at www.anthem.com. Registered users of the Anthem online portal can log in, click *Claim & Payments* and choose *Submit a Claim* to begin the process. To complete your claim submission, you will supply a few key pieces of information, upload your documents and click *Submit*. You will receive instant confirmation that your claim has been submitted. Visit www.dgaplans.org/filing-a-claim for more detailed instructions for filing your claims at www.anthem.com.



Once the Plans office has processed the claim, detailed claims information and a downloadable Explanation of Benefits (EOB) will be available on the **myPHP** online benefits portal at www.dgaplans.org/myPHP. You must be a registered **myPHP** user to access your claims information.

PLEASE NOTE: Though **myPHP** provides many important online services, claims submissions must go through Anthem. Submitting claims through **myPHP** will severely delay processing.

2 Submit claims timely.

You have one year from the date of service to file a claim. Any claims received after this deadline will be denied.



Timely filing is even more important if the Health Plan is your secondary insurer. The Health Plan will not pay claims until your primary insurance has paid their portion of the claim. Once your primary insurance pays, you can submit your claim and the EOB from your primary insurance to Anthem. The longer your primary insurance takes to pay, the less time you have to submit your claim to the Anthem, and the more likely you are to exceed the timely filing deadline.

Submitting claims as soon as possible after the date of service ensures timely processing and can prevent unanticipated out-of-pocket costs.

3 Don't let claims accumulate.

The Health Plan only pays benefits on claims that are medically necessary and reviews claims for medical necessity on a regular basis. Submitting your claims as they are incurred not only ensures your claims are filed timely, but can also help you avoid billing surprises that may occur if your claims are later determined to not be medically necessary. In those cases, you may be responsible for paying for any denied claims out of pocket.

However, if you submit claims as you go, the Health Plan can notify you when a claim is denied for not being medically necessary so that you can decide if you want to continue treatment without the Health Plan's benefits. **PH**

Managing Your Benefits Has Never Been Simpler

with the

myPHP online benefits portal



Inbox ⁴

Contributions

Pension

Health Eligibility

Health Claims

Documents and Forms

Six easy-to-use tabs keep your information organized **How to create your free myPHP portal account**

The **myPHP** online benefits portal organizes your benefits information into six simple tabs, making it easier to find exactly what you need whenever you need it.

- 1. Inbox.** Instantly receive your pension and health documents electronically instead of waiting for the mail. **myPHP** notifies you via email whenever a new document is ready for viewing.
- 2. Contributions.** View, sort, filter, or print your pension and health contributions processed by the Plans office.
- 3. Pension.** Check your estimated Basic Plan benefits and view your Supplemental Pension Plan account balance.
- 4. Health Eligibility.** Check your Health Plan Eligibility status.
- 5. Health Plan Claims.** View claims information for you and your dependents. Print copies of your Explanations of Benefits.
- 6. Documents and Forms.** View, print or download your pension and contributions statements. Upload documents directly to the Plans office.

The **myPHP** online benefits portal is available to you and your dependents age 18 and over. Register today to access your benefits information wherever you have an internet connection.

To create your account, have your Plan ID number ready, and follow the simple steps below.

TO CREATE AN ACCOUNT:



1. Go to **www.dgaplans.org/myPHP**.
2. Click Register.
3. Follow the prompts to complete your registration.

For technical assistance with registering for your account, call (323) 866-2200, Ext. 409, Monday–Friday, 8:30 a.m. to 5:00 p.m. Pacific Time. For all other benefits-related questions, call Participant Services at (323) 866-2200, Ext. 401.

Day Unit →
Laboratory →

Requesting a Predetermination from the Health Plan Before Your Surgery Can Help You Avoid Unexpected Costs

If you are planning to have surgery, an important step in preparing is to make sure that your procedure is covered by the Health Plan.

The Health Plan covers medically necessary visits, treatments and procedures for covered participants and their dependents. One of the Health Plan's criteria for determining medical necessity includes whether the procedure or service is consistent with generally accepted medical guidelines and practices, which may require that certain evaluation or treatment options be performed prior to or instead of others. When standard medical practice is not followed, a treatment will be deemed not medically necessary and, therefore, will not be covered under the Health Plan.

While you might assume that whatever treatment plan your doctor recommends is considered medically necessary under the Health Plan, this may not be the case if the treatment plan is not consistent with standard medical practices. If surgery is performed but later determined not to have been medically necessary, you may be held responsible for the full cost of the procedure, leaving you with significant unanticipated expenses.

A predetermination is a written analysis, provided by the Health Plan upon request, which evaluates the medical

necessity of a particular procedure or treatment before you receive it. A predetermination will provide you with information on how the Health Plan might apply benefits for the service in question, but it does not guarantee coverage. A final determination of coverage can be made only after the procedure has been performed, upon processing the claim and reviewing any additional information and records submitted.

Predetermination vs Preauthorization

A "predetermination" is not the same as a "preauthorization." Predetermination is a voluntary request for information from the Health Plan to help determine ahead of time whether a treatment might be considered medically necessary and estimate Health Plan coverage.

Preauthorization, on the other hand, is a required step your provider must take to confirm Health Plan coverage for certain services, including inpatient hospital stays, residential care, partial hospitalization, intensive outpatient treatment and certain prescription drugs. Preauthorizations are conducted by Anthem Blue Cross's Utilization Management Department. In contrast

to predeterminations, preauthorizations guarantee the authorized procedures will be covered.

Two Common Surgeries For Which Predeterminations Are Recommended

The most common surgeries for which voluntary predeterminations are recommended are orthopedic surgeries and nasal surgeries. Here are some things to consider about each:

Orthopedic Surgery

Orthopedic surgeries might be recommended by doctors as a first course of treatment. However, surgery as a first response is generally not standard medical practice in treating orthopedic conditions and may not be considered medically necessary by the Health Plan. If your doctor is advising that your condition does not require standard medical care prior to surgery, the rationale for



ORTHOPEDIC SURGERIES treat the bones and joints. It is recommended that you request a predetermination for all orthopedic surgeries.



this decision needs to be clearly documented in your medical records.

According to standard medical practice, before advancing to orthopedic surgery, you should have first tried some or all of the following modalities/studies:

- ▶ Nonsteroidal anti-inflammatory drug;
- ▶ Physical therapy;
- ▶ Home exercise program;
- ▶ Cortisone injections;
- ▶ Medications; and
- ▶ Diagnostic imaging confirming the diagnosis.

When in doubt, review any planned procedures with your doctor so you have a full understanding of your surgery and its costs. If you are uncertain as to whether your orthopedic surgery is medically necessary, you should request a voluntary predetermination from the Health Plan before receiving the service. A predetermination will help you evaluate ahead of time whether the treatment is considered medically necessary and whether it will be covered.

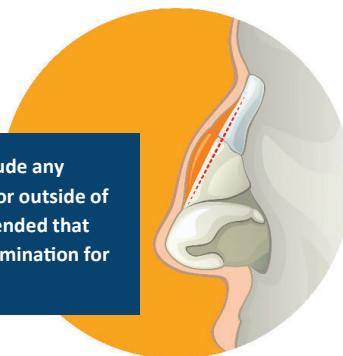
Nasal Surgery

For nasal conditions such as a deviated septum or chronic sinusitis, doctors

sometimes recommend immediate surgery, even though standard medical practice—similar to the orthopedic surgery example—suggests utilizing non-surgical treatments prior to considering surgical intervention.

According to standard

NASAL SURGERIES include any surgeries on the inside or outside of the nose. It is recommended that you request a predetermination for all nasal surgeries.



medical practice, before advancing to nasal surgery, you should have first tried some or all of the following with no success:

- ▶ Decongestants;
- ▶ Nasal steroid sprays;
- ▶ Antihistamines for Nasal Septum Deviation;
- ▶ Saline nasal irrigation for Chronic Sinusitis (ex: Neti Pot),
- ▶ Antibiotics; and
- ▶ Allergy evaluation.

Be aware, however, that even if you

have followed standard medical procedure, given the complex nature of nasal surgery, some features of a surgery may be considered medically necessary while others may not. Rhinoplasty, for example, will likely be considered not medically necessary, as will any other cosmetic procedure.

Conclusion

One way to avoid unexpected out-of-pocket costs for your surgery is to request a predetermination from the Health Plan before the surgery is performed. Although a predetermination is not a guarantee of coverage, it will provide

useful information about your potential out-of-pocket costs for a procedure so that you and your doctor can proceed accordingly. By requesting the predetermination, you can avoid surprise expenses.

If you are planning a surgery or would like information on how to request a voluntary predetermination from the Health Plan, visit www.dgaplans.org/Predeterminations. You can also contact the Health Plan's Participant Services Department at (877) 866-2200, Ext. 401.

PH



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