

Board of Trustees Acts to Expand Coverage of Abortion Services to Dependent Children and Abortion-Related Travel Costs

Trustees also reconfirm the Health Plan's existing coverage of both elective and medically necessary abortions, including abortion-related prescription drugs

In response to the recent ruling by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization*, the Directors Guild of America–Producer Health Plan reaffirms its existing coverage of all medically necessary and elective abortion services, including broad access to abortion-related prescription drugs, for covered Health Plan participants and dependent spouses. Additionally, the Board of Trustees has expanded coverage to include such services for dependent children, regardless of whether

there are complications from pregnancy, and related travel and lodging costs for participants and beneficiaries who live or work in covered employment in states where abortion services are not permitted.

As it always has, the Health Plan will continue to cover abortion services without regard to the reason. Coverage will continue to include medical treatments and access to abortion-related prescription drugs (e.g., the “Plan B” or “Morning After” pill) per Health Plan rules.

No preauthorization is required for the travel and lodging benefits at this time, but you may be required to attest to the Health Plan in the future that the specified services were not legally available in the current jurisdiction for you, your spouse or dependent child.

Travel Benefits

Effective July 18, 2022, the Health Plan will reimburse travel for you, your dependent spouse or your dependent child, and one medically appropriate support companion, when travel is necessary because termination of a pregnancy is not legally available in your state of residence or in the state where you are currently employed or engaged in covered employment.

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ON BENEFITS

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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.

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Board of Trustees Expands Coverage for Abortion Services, Effective July 18, 2022

The Health Plan will only reimburse necessary travel expenses to your state of residence or to the nearest state in which abortion services are legally available.

Travel benefits include:

- ▶ Reimbursement for 100% of the actual cost for round trip "coach" airfare;
- ▶ Reimbursement for 100% of the actual cost for travel via trains, subways, buses, taxis, rideshares, or other public transportation; and
- ▶ Mileage reimbursement for use of a personal vehicle at the applicable rate set forth by the Internal Revenue Service and updated from time to time (e.g., 62.5 cents/mile in 2022).

Lodging Benefits

Effective July 18, 2022, the Health Plan will reimburse reasonable lodging expenses for you, your dependent spouse or your dependent child and one support companion when travel is necessary to receive the specified services. Lodging must be for, and in connection with, receiving abortion services, and not for personal pleasure, recreation, or vacation.

Lodging expenses are not available if you, your spouse or your dependent child travel to your state of residence in order to receive the specified services.

Lodging benefits include:

- ▶ Coverage for the night prior to and during the course of receiving the specified services; and
- ▶ Reimbursement based on reasonable rates for the city in which treatment is provided, not to exceed \$300 per night.

For example, if you travel to receive an abortion procedure on August 1, 2022, the Health Plan will cover lodging costs for the night before the procedure (July 31st), and the night of the procedure (August 1st).

Lodging reimbursements that exceed the maximum rate set forth by the Internal Revenue Service as updated from time to time will be reported as income to you, your spouse or your dependent child, as applicable. You will receive a Form 1099 for any excess amount.

All expenses, including itemized receipts, must be submitted in accordance with Plan rules for reimbursement.

Meals, car rentals, international travel, personal care items and car maintenance are examples of items that are not reimbursable by the Health Plan. Additional terms may apply, and there may be additional expenses not covered by the Health Plan. For full details about the Health Plan's coverage of abortion services, refer to the 2020 Health Plan Summary Plan Description and its updates, available at www.dgaplans.org/health-plan-booklet. **PH**

What is Medical Necessity, and How Does it Impact Coverage?



When a healthcare provider prescribes a test or course of treatment, you might assume that whatever the doctor orders for you is medically necessary simply because the doctor has ordered it. However, when it comes to what is covered under the Health Plan—which often determines how much you pay out-of-pocket for services—the concept of “medically necessary” is specifically defined and one with which you should be familiar.

The Health Plan only covers services determined to be medically necessary. The Health Plan defines a treatment, service or supply as medically necessary when it is:

1. Consistent with generally accepted medical practice within the medical community for the diagnosis or direct care of symptoms, sickness or injury to the patient, or for routine screening examination under wellness benefits;
2. Ordered by the attending licensed physician or dentist and not solely for your convenience, your physician, hospital or other healthcare provider;

3. Consistent with professionally recognized standards of care in the medical community with respect to quality, frequency and duration; and
4. The most appropriate and cost-efficient treatment, service or supply that can be safely provided, at the most cost-efficient and medically appropriate site and level of service.

Even though a provider may order a treatment or test, the Health Plan will not cover it if it does not meet all four criteria listed above.

To learn about the Health Plan’s standards for medical necessity related to physical therapy treatment and labs and tests, read:

- ✓ “Three Ways to Ensure that Your Physical Therapy Costs are Medically Necessary and are Covered by the Health Plan” on page 5 and
- ✓ “Avoid Out-of-Pocket Costs for Labs and Tests” on page 6. **PH**

Manage your DGA pension and health benefits online

The myPHP online benefits portal puts everything you need for managing your pension and health benefits at your fingertips. Visit www.dgaplans.org/myPHP to create your account today.



A myPHP online benefits portal account lets you:

- Check your estimated pension benefits
- Check your Health Plan eligibility status
- Verify your pension and health contributions
- Get Plans' mail delivered electronically
- Upload documents directly to the Plans Office

To register for myPHP, have your Plan ID number ready, and go to www.dgaplans.org/myPHP. Click Register to begin the registration process. For registration support, call (323) 866-2200, Ext. 409, or email myphp-support@dgaplans.org.

Register at: www.dgaplans.org/myPHP



Making Sure Your Private and Sensitive Personal Information Remains Secure is Our Priority

The Plans take extensive measures to ensure your private and sensitive personal information remains secure – both from a cybersecurity and physical security standpoint. Most of today's talk about data privacy and security revolve around the more high-tech tactics criminals use to steal information, like phishing, spear phishing and SMiShing. While we employ a number of sophisticated techniques to protect your data, identity thieves are reverting to a more tried and true method of separating you from your personal information - the telephone.

What is Account Takeover Identity Theft?

Account takeover fraud is a type of identity theft in which a criminal effectively poses as a victim—whether online, in person or over the phone—to take control of accounts for financial gain. Reports estimate that losses from account takeover fraud totaled \$56 billion in 2020; and in the first quarter of this year, 22% of all U.S. adults were affected. This means that you, your Plan ID and your pension and health assets are more attractive than ever to would-be thieves. As a result, the Plans make

protecting your information one of our top priorities.

How Our Questions and Security Protocols Help You

When you call the Plans' office, you may be asked more than one security question before we release any information to you, or you may be asked to provide documents proving your identity before changes can be made to your demographic information. While this might feel like a hassle, it is one of our first lines of defense in protecting your identity and assets.

Why *so many* questions?

A single security question is often not enough to prevent account takeovers due to the vast amount of personal information most people make available online. Seemingly harmless information posted on social media can offer a buffet of details that identity thieves can use to impersonate you. In fact, social media users have a 46% higher risk of account takeover fraud than those not on social media. Basic information like the name of your high school from a post about your 10-year reunion or your pet's name can give thieves exactly what they need to bypass certain security questions.

How many times have you seen the name of your high school mascot or the name of your childhood pet as a security question?

Once criminals have enough of your information, they can use it in endless ways. Successful account takeovers have ended in stolen 401(k) assets, illegally received medical treatment and even illegitimate transfers of homes. To protect against fraudulent access to your pension and health plan data, the Plans remain extra vigilant by verifying each caller's identity to ensure that information is provided only to those with authorized access. This usually requires more than one identifying question.

How You Can Protect Yourself

Actions you can take to protect your assets and identity include regularly checking your medical records and account statements for unfamiliar activity, limiting the amount of personal information offered online and remaining aware of new threat scams. Just a few small actions can help prevent identity thieves from wreaking havoc on your assets, medical records and sense of security. **PH**

Three Ways to Ensure that Your Physical Therapy Costs are Medically Necessary and are Covered by the Health Plan

The Directors Guild of America-Producer Health Plan ("Health Plan") only covers physical therapy visits that are deemed medically necessary. Understanding when physical therapy is not medically necessary including how to tell when your therapy program has become maintenance or training—will help you avoid unexpected out-of-pocket costs. Listed below are simple actions you can take before and throughout treatment to help ensure that you stay informed of what your costs may be.

1. Before Starting Treatment, Submit Your Referral

The Health Plan does not require preauthorization for physical therapy, but it does require a copy of your physician's referral before physical therapy services can be covered. Before beginning treatment, confirm with your referring physician that your referral was sent to the Health Plan or submit the referral yourself. Health Plan staff will review the referral to ensure that it is valid and will request additional information, if necessary. To submit a referral for physical therapy, email a copy to hpclaims@dgaplans.org or fax it to the Health Plan at (323) 787-9287.

2. File Your Claims Timely

It is important throughout your course of treatment that you regularly submit your physical therapy claims to the Health Plan and refrain from submitting them in bulk. Although network providers will likely submit your claims for you as incurred, most non-network providers will require you to submit claims yourself.

It is best to submit these claims as they are incurred so that you can accurately track the Health Plan's processing of the claims. This practice allows the Health Plan to determine its coverage of your treatment as it progresses and to communicate with you before any changes in coverage (*i.e.*, changes in your out-of-pocket responsibility) occur. You can then act accordingly before additional claims are incurred.

3. Monitor Your Progress

Ongoing services like physical therapy may reach a point where medically necessary therapy (which is covered by the Health Plan) becomes maintenance or training (which is considered not medically necessary and therefore, is not covered by the Health Plan). Continued treatment without a clear understanding of whether it still meets the standard of medical necessity increases your chances of out-of-pocket costs for such treatment.

The checklist below can help you determine if your physical therapy has transitioned from medically necessary to maintenance or training.



Has My Physical Therapy Moved from Medically Necessary to Maintenance or Training?

Use the questions below to help monitor your condition's progress during physical therapy treatment. If you answer "yes" to any of the questions below, contact the Health Plan to learn more about your costs for continued treatment.

- | | |
|--|---|
| <input type="checkbox"/> Is my treatment continuing solely to maintain my present level of strength, pain, function, activity, etc.? | <input type="checkbox"/> Am I asymptomatic? |
| <input type="checkbox"/> Could a home exercise program be used instead? | <input type="checkbox"/> Have I met the objective of my initial treatment plan? |
| <input type="checkbox"/> Has my condition stabilized (<i>i.e.</i> , not getting worse or not improving)? | <input type="checkbox"/> Is my physical therapist recommending therapy beyond the time period specified in the initial treatment plan without re-evaluation by my referring provider? |
| <input type="checkbox"/> Has my physical therapist asked to move from treating my condition to solely monitoring my condition? | <input type="checkbox"/> Is physical therapy no longer the most cost-efficient service to address my condition? |
| <input type="checkbox"/> Is physical therapy no longer | |

If at any point during your course of treatment you can continue with a home exercise program, any further visits would be considered training and would not be medically necessary. Additionally, if you answer "yes" to any of the questions on the checklist, contact the Health Plan office to ask about coverage for continued physical therapy. Therapy may no longer be considered medically necessary by the Health Plan, which means that any treatment sessions could become your financial responsibility.

For more about the criteria used by the Health Plan to determine medical necessity, refer to the definition of Medically Necessary on page 114 in the March 2020 Health Plan Summary Plan Description available at www.dgaplans.org. If you would like a copy mailed to you at no cost, please contact the Health Plan. **PH**

Avoid Out-of-Pocket Costs for L

Labs and tests are a routine part of most doctor visits and are rarely questioned. Patients tend to assume that anything their doctor orders must be necessary for treatment and, therefore, will be covered by their insurance. However, this may not be the case.

The Health Plan covers only services that are deemed medically necessary, and this includes testing. Before completing labs or tests, you should know the steps you can take to better understand whether they are medically necessary so that you avoid having to pay for expensive tests deemed not medically necessary by the Health Plan.

Talk to Your Doctor

Discussing with your doctor the details of any recommended labs or tests can give you a more accurate assessment of what the Health Plan might cover and what your out-of-pocket expenses may be. The information you gather can also better guide your next steps, which should include working with your doctor to contact the Health Plan as discussed in the *Talk to the Health Plan* section. You can begin the conversation with your provider using the three questions below:

1. Why are these tests being ordered?

Although the answer to this question may seem obvious, medical providers order labs and tests for various reasons depending on your treatment and circumstances. When discussing this question with your doctor, listen for terms like "investigational," "new" or "experimental," and obtain assurances that the tests are being ordered to specifically address the symptom or condition that is being evaluated. Tests may not be considered generally accepted medical practice or part of professionally recognized standards of care and, therefore, will not be covered by the Health Plan.

2. How will these labs or tests affect my overall treatment plan?

When trying to determine whether tests or labs may be covered by the Health Plan, consider the explanation your doctor gives for how the results will be used. Seek to understand whether the results will directly determine the next steps of your treatment plan.

3. Is this a repeat test or a genetic test?

In the case of repeated tests or genetic testing, ask your doctor to contact the Health Plan to determine coverage. Repeating tests may be a routine practice for a given provider or facility, but the Health Plan may have a limit on how often a particular test can be performed to be deemed medically necessary. When it comes to genetic testing, although such tests have grown in popularity, they may be used for investigational or informational purposes only, which would not be considered medically necessary. For additional tests that are not covered by the Health Plan, refer to the chart on the next page.

Knowing the answers to these questions can prepare you for the next steps in understanding whether the tests being ordered for you are considered medically necessary and covered by your insurance. The *Talk to the Health Plan* section below discusses how to use such information to determine whether your provider should contact the Health Plan to request a predetermination.

Talk to the Health Plan

After talking with your doctor about the tests being ordered, you can request that your provider contact the Health Plan for an assessment of whether those tests are considered medically necessary. This voluntary request for information is called a predetermination and can help you estimate the coverage for the services.

A predetermination is a written analysis that informs you whether the lab or test being

abs and Tests

Tests that are Not Covered by the Health Plan

The labs and tests below are not considered medically necessary by the Health Plan. Before completing them, make sure to understand what your out-of-pocket costs will be.

Diagnostic	<ul style="list-style-type: none">• Laboratory and diagnostic test and services to treat sickness or injury that have not been ordered by a physician or are not medically necessary;• Lab, x-ray, and other diagnostic testing ordered by a licensed acupuncturist, whether designated by that term or by another term such as "Oriental Medical Doctor," even if the testing is performed by a physician;• Musculoskeletal x-rays ordered by a chiropractor, even if such tests are administered or interpreted by a medical doctor; and• Orthoptics or vision therapy and any associated supplemental testing.
Psycho-educational	Academic evaluations, psychological or neuropsychological testing of school age children that are not medically necessary
Frequent/Repeated	Urine drug screenings that are qualitative presumptive and administered more than once
Experimental/Investigational	Molecular or genomic tests, epigenetic tests and gene-based assays

requested is covered and, if so, to what extent. It is not a preauthorization or guarantee of coverage but allows you to potentially avoid out-of-pocket costs later.

To start the predetermination process, your provider should submit the applicable medical records and a letter of medical necessity, including diagnoses and procedure codes for the services being considered, to the Health Plan Claims Department via fax at (323) 866-2351 or via email at hpclaims@dgaplans.org. After the information is reviewed by the Health Plan, you will receive a written response that assesses the medical necessity of the tests. If your provider has any questions about this process, the provider should contact the Health Plan at (323) 866-2200, Ext. 401. **PH**

Pay Health Premiums More Easily with Automatic Pension Deduction



Whether you spend your retirement at leisure or on the go, paying your Health Plan premiums through automatic pension deduction goes perfectly with your lifestyle.

If you are receiving a monthly benefit from the Directors Guild of America-Producer Basic Plan and are on Certified Retiree coverage, you can make convenient, recurring premium payments by having your premiums automatically deducted from your monthly pension benefit. As long as your pension benefit covers your premium amount, you can rest assured that your payment will be made timely with no further action from you.

To enroll in automatic pension deduction, you must complete and return the Pension Deduction Authorization Form available at www.dgaplans.org/forms/health/. If your completed form is received by the 15th of the month, pension deduction will begin the following month. Deductions will equal the amount of your monthly Certified Retiree premium. This option is not available for dependent premium payments.

For more information, contact the Health Plan Eligibility Department at (323) 866-2200, Ext. 502. **PH**

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Health Fairs this Fall in LA and NYC

The Directors Guild of America-Producer Pension and Health Plans will be hosting health fairs and free flu shot clinics exclusively for DGA members and their families (regardless of Health Plan coverage status) in Los Angeles and New York City this fall. Plan now for the event nearest you:

Los Angeles

Saturday, October 1

9:00 a.m. to 1:00 p.m.

DGA Lobby, Los Angeles

7920 Sunset Boulevard

New York City

Saturday, October 15

2:00 p.m. to 5:00 p.m.

DGA New York Theater Lobby

110 West 57th Street

Free Flu Shots

Reservations are required and can be made at www.dgaplans.org/flushots.

Flu shots are available to all DGA members and their dependents age 13 and over. The DGA Foundation is covering the cost of the flu shots for participants not covered under the Health Plan. Women who are pregnant or nursing can request a preservative-free flu shot. High dose vaccines will be available upon request for participants age 65 and older. When making your reservation, please select the type of flu shot you want to ensure it is available for you.

myPHP Information Booth

- ▶ **Learn about the myPHP benefits portal**, where participants in the Health and Pension Plans can access their personal benefits information—including Health Plan eligibility, medical claims, employer contributions, estimated pension benefit accruals and more—wherever you have internet access!
- ▶ **Participants who subscribe to myPHP for the first time and go paperless and current myPHP subscribers who go paperless at the Health Fair's myPHP information booth** will be entered into a raffle drawing for a GoPro Hero10.

Back by Popular Demand

- ▶ **Free Neck and Shoulder Massages**
- ▶ **One-on-One Time with Plans' staff and representatives from the Health Plan's partners**, including CVS, Delta Dental, VSP, MPTF and the Entertainment Community Fund (formerly the Actors Fund)
- ▶ **Raffle Prizes and Giveaways**, including a chance to win a \$100 Amazon Gift Card, an Apple Watch Series 7 with GPS, a GoPro Hero10 and MORE! **PH**