Spotlight ON BENEFITS

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Spotlight 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.

Pension and Health Plans Changes for 2024

Reading Time: 9 minutes

1 Health Plan Partners with Green Light Cost Management to Obtain Lower Payments for Non-Network Claims for You and the Health Plan

The DGA–Producer Health Plan has partnered with Green Light Cost Management to help negotiate lower rates for non-network claims and eliminate balance billing whenever possible. With Green Light, the Health Plan will be better able to reduce out-of-pocket costs when you use non-network providers, as well as reduce overall costs to the Health Plan.

In order to provide Green Light the opportunity to try to negotiate better pricing for you, it is important that you do not pay the non-network provider up front. (See *Tips to Avoid Paying the Entirety of Your Non-Network Medical Bill Up Front* at right.) Instead, ask your non-network provider to submit your claim electronically through the Health Plan's normal claims filing process. If you pay up front, you may lose out on potential savings that could have been achieved through the negotiation process with Green Light and be subject to a lower reimbursement amount from the Health Plan for your claim. If you disagree with the reimbursement amount, you may file an appeal with the Health Plan to have the reimbursement amount reviewed.

"Reasonable and Customary" Re-Defined

The definition of "Reasonable and Customary" under the Health Plan, which is used to determine the standard payment amounts for non-network claims, is changing effective January 16, 2024 to 150% of the Medicare reimbursement rate. Prior to this change, "Reasonable and Customary" was defined by the Health Plan as the charge or fee level that is equal to or less than the charge that 80% of the physicians of a similar specialization in a given geographic area would charge for a specified procedure.

Beginning with claims received by the Health Plan on or after January 16, 2024, the "Reasonable and Customary" pricing standard the Health Plan uses

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Tips to Avoid Paying the Entirety of Your Non-Network Medical Bill Up Front

1. **Ask your provider to submit your claim electronically through the normal claims filing process.** This will allow Green Light the opportunity to negotiate better pricing for you. If you pay up front, you may lose potential savings that could have been achieved through the negotiation process from Green Light.
2. **Ask your provider for the least amount you can pay at your appointment.** If you must pay up front, pay as little as possible to increase your chances of full reimbursement after the claim is submitted.
3. **Negotiate a lower price for the services with your provider.** If you must pay your entire bill to receive services, negotiate the price using Medicare's rate as a standard. Providers may be willing to discount the initial quoted price for patients who pay up front. To find Medicare rates, go to **www.medicare.gov/procedure-price-lookup/**.

1 Green Light Cost Management to Negotiate Lower Payments for Non-Network Claims (cont'd)

to pay non-network claims will be defined as the charge or fee that is the lesser of: (1) actual billed charges; (2) 150% of the applicable Medicare reimbursement rate for a specified procedure; or (3) in the event there is no Medicare reimbursement rate for a specified procedure or it cannot be determined based on the information submitted, the amount that would be paid to a similar provider for the same or similar service or item in the same geographic location or locality. The schedules of the maximum Reasonable and Customary rates are adjusted periodically.

The Health Plan's maximum allowable charge for any medical procedure or service from a non-network provider will not exceed the applicable Reasonable and Customary amount noted previously. You are responsible for any charges from non-network providers in excess of the maximum allowable charge and all non-covered expenses, except with respect to emergency services, non-emergency services received from a non-network provider at certain network facilities, and air ambulance services furnished by non-network providers.

Here's how the Health Plan's partnership with Green Light will work:

FOR U.S. CLAIMS:

1. Submit your non-network claim to Anthem Blue Cross via your online Anthem account, fax or mail. DO NOT submit claims to the Health Plan office.
2. Your non-network claim is then received by the Health Plan.
3. The Health Plan, in partnership with Green Light, will determine the portion of the claim's billed amount the Health Plan will pay under its terms.

IF THE CLAIM IS LESS THAN $500, the Health Plan will pay the Reasonable and Customary amount on any covered expenses, as defined previously (usually 150% of Medicare's reimbursement rate). You will be responsible for any amounts in excess of the Reasonable and Customary amount plus any expenses not covered under Health Plan rules.

NOTE: When possible, similar or related claims will be bundled to meet the $500 threshold.

IF THE CLAIM IS MORE THAN $500 AND YOU HAVE NOT YET PAID THE PROVIDER:

a. Green Light will attempt to negotiate with the provider on your behalf to determine a mutually agreeable allowance. A Reasonable and Customary rate equal to 150% of Medicare's reimbursement rate will be the basis of the negotiation.

b. If Green Light is able to negotiate a more favorable rate with your non-network provider, you will be responsible for any applicable deductible and co-insurance based upon the negotiated rate on covered expenses. As part of the pricing arrangement with Green Light, the non-network provider will agree not to balance bill you for any remaining charges.

   If Green Light and your provider are unable to reach a negotiated rate agreement, the Health Plan will pay the standard Reasonable and Customary rate, as defined previously (usually 150% of Medicare's reimbursement rate) on any covered expenses. You may be balance billed by the non-network provider for any amount in excess of the Reasonable

and Customary rate plus any expenses not covered under Health Plan rules.

IF THE CLAIM IS MORE THAN $500 AND YOU HAVE ALREADY PAID THE PROVIDER:

The Health Plan will reimburse you at the Reasonable and Customary amount (150% of Medicare's reimbursement rate) for any covered expenses. If you disagree with the reimbursement amount, you may file an appeal with the Health Plan to have the reimbursement amount reviewed.

FOR INTERNATIONAL CLAIMS:

1. Submit an International Claim Form along with your itemized bill to BlueCross BlueShield Global Core.
2. You will be reimbursed the Reasonable and Customary rate of 150% of the Medicare rate according to the New York City metropolitan area. If you disagree with the reimbursement amount, you may file an appeal with the Health Plan to have the reimbursement amount reviewed. **PH**

2 CVS Updates Its List of Covered Medications, Effective January 1, 2024

CVS Caremark, the Health Plan's prescription drug benefit manager, periodically reviews and updates its list of covered medications, called the Advanced Control Formulary, to ensure continued access to safe, effective treatments in all drug classes. Changes to the formulary affect which medications are covered by the Health Plan and how much you pay out of pocket for prescriptions.

Effective January 1, 2024, CVS Caremark is revising its list of covered formulary medications. If you are currently taking a medication that will be excluded from the revised formulary, CVS Caremark should have already mailed you a letter with information on alternatives. If you are taking a maintenance medication, be sure to review the new list in case the status of your medication has changed. The complete 2024 list of excluded medications along with preferred alternatives is available at **www.dgaplans.org/formulary**. **PH**

3 All-Inclusive Network Out-of-Pocket Limit Increases Effective January 1, 2024 as Established Under the Affordable Care Act

The All-Inclusive Network Out-of-Pocket Limit sets the maximum amount you may be required to pay out of pocket per calendar year for network benefits under the Health Plan. The All-Inclusive Network Out-of-Pocket Limit includes any deductibles, co-insurance and co-payments (such as prescription drug co-payments, the $50 emergency room co-payment and the $10 co-payment for visits to the UCLA/MPTF health centers). The Health Plan indexes this limit annually in line with the amount established each year under the Affordable Care Act.

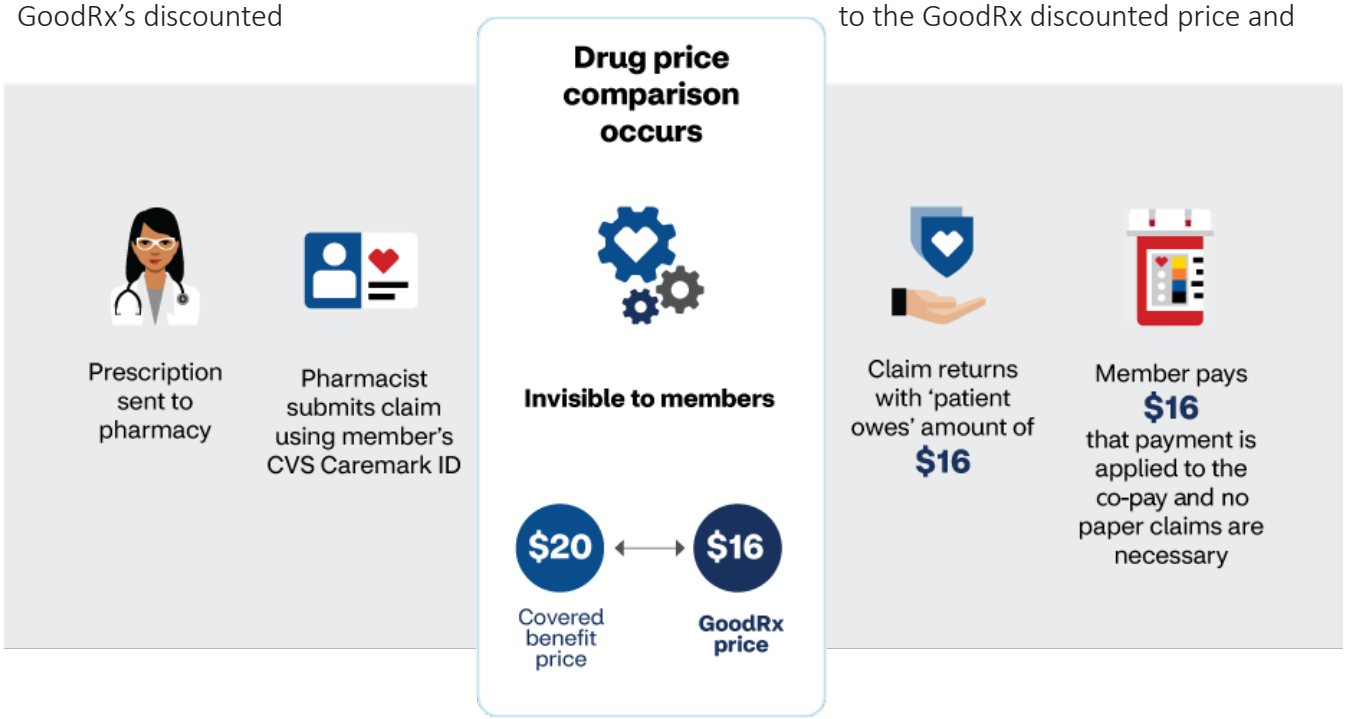
Accordingly, beginning January 1, 2024, the Health Plan's All-Inclusive Network Out-of-Pocket Limit will increase from $9,100 individual/$18,200 family to $9,450 individual/$18,900 family for all coverage plans. If you reach the limit, the Health Plan will pay 100% of covered network expenses. **PH**

4 New Prescription Drug Benefit Enhancement Lowers Out-of-Pocket Costs on Non-Specialty Generic Medications

Beginning January 1, 2024, covered non-specialty generic medications will automatically be charged at the lesser of: (1) the GoodRx discounted price; or (2) your normal prescription drug co-payment.

Participants will no longer have to shop around for the best prices on non-specialty generic drugs. As of January 1, 2024, the new Cost Saver Program from CVS Caremark—the Health Plan's prescription drug benefit manager—brings GoodRx's discounted drug pricing to the Health Plan's prescription drug benefit. CVS Caremark's partnership with GoodRx, a prescription drug price comparison and savings service, allows covered Health Plan participants to automatically pay the lower price, even if it is below the normal prescription drug co-payment.

The lower price will be charged automatically. All participants need to do is fill their prescription at a network pharmacy, using their CVS Caremark benefit card. CVS Caremark will compare your regular generic drug co-payment amount to the GoodRx discounted price and select the lower price of the two. The graphic above details the process. PH



5 Board of Trustees Extends the Availability of Temporary Loans from Your Supplemental Pension Plan Account Balance Through March 31, 2024

To assist participants experiencing financial hardship due to the WGA and SAG-AFTRA strike-related work stoppage, the Board of Trustees of the Directors Guild of America – Producer Pension and Health Plans has voted to extend the availability of temporary loans from the Supplemental Pension Plan through March 31, 2024. Loans were originally made available through December 31, 2023.

See below for a summary of key loan terms and exclusions.

Summary of Key Loan Terms and Exclusions

(Refer to the Supplemental Plan loan application for a complete description of loan terms.)

Key Loan Terms

- Loan amount is limited to the lesser of $40,000 or 20% of your account balance.
- Minimum loan amount is $1,000.
- Loan amounts will be permitted only from the vested portion of your account balance.
- Interest rate for every loan is set at prime plus 1% and is fixed for the life of the loan.
- Up to four (4) outstanding loans (not to exceed the lesser of 20% of your account balance or $40,000 in total) will be allowed at any time during the loan availability period. This includes any existing loans.
- Loan repayments must be made quarterly, beginning with the first day of the quarter, following the first full quarter after the quarter in which the loan is distributed. Payments are due to the Supplemental Pension Plan on the first day of each quarter.
- Loan repayments must be made to the Supplemental Plan on an after-tax basis. Repayments are considered made on the date postmarked or transmitted.
- Loan must be fully repaid, plus interest, within five (5) years and can be repaid in full at any time without penalty.
- For married participants, spousal consent will be required for loans of $5,000 or more.

Exclusions

- Loans will not be permitted for participants whose Supplemental Plan accounts are subject to a qualified domestic relations order (QDRO), unless such QDRO is a separate interest QDRO, and the participant's and alternate payee's accounts have been segregated.
- Only general-purpose loans are available under the Supplemental Plan. No primary residence loans are permitted.

Before applying for a loan, participants are encouraged to seek alternative means of support to preserve retirement funds to the extent possible. It is important to understand the negative implications if you default on your loan, which may result in federal excise taxes, early withdrawal penalties and missed investment returns. For more information, visit the Plans' website at **www.dgaplans.org**.

For the full terms and application, go to **www.dgaplans.org/loanterms**. **PH**

Health Plan's Infertility Benefit:

Obtaining a Diagnosis - What Is and Is Not Covered

Reading Time: 2 minutes

In recognition of the challenges faced by many of our participants pursuing parenthood, the Directors Guild of America-Producer Health Plan began offering infertility benefits—managed by Carrot—to qualifying covered participants and dependent spouses effective July 1, 2022 for medically necessary infertility treatment based upon a medical diagnosis of infertility.

Any participant or dependent spouse, including same-sex spouses and gender diverse spouses, with a diagnosis of infertility from their provider is eligible for the $30,000 lifetime benefit, provided they are covered under Earned Active, Earned Inactive, Regular Carryover, or related COBRA Continuation coverage with the Health Plan.[1]

Obtaining a Diagnosis of Infertility

Neither Carrot nor the Health Plan make the diagnosis of infertility. Only your provider can provide you with this diagnosis.

Medical providers can determine infertility based on **any** generally accepted medical guidelines. While the Centers for Disease Control (CDC) guidelines state that in general, infertility is defined as not being able to get pregnant after at least one year of unprotected sex, providers can make the diagnosis based on any number of guidelines, including, but not limited to, those issued by the American Society of Reproductive Medicine (ASRM). Unlike the CDC guidelines, the ASRM recently updated its guidelines to define infertility as a disease, condition, or status including the following:

- The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
- The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner.

Regardless of which guideline is used, if you or your spouse has a medical diagnosis of infertility from your provider, you are eligible for the $30,000 lifetime

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1 This excludes participants and spouses on Extended Self-Pay coverage, Retiree coverage, or any other Self-Pay coverage.

benefit for family forming ($60,000 if both of you are diagnosed with infertility).

Infertility Benefits Not Covered by Carrot

In order for the Health Plan to provide medical benefits to you on a non-taxable basis, the benefit must be a reimbursement for "qualifying medical expenses" (QMEs) as defined in Internal Revenue Code Section 213(d).

The definition of QMEs is complicated, but under the IRS rules, QMEs do not include fertility benefits, including in vitro fertilization **not performed on you or your eligible spouse**, or expenses incurred by donors or gestational surrogates.

In addition, only services provided by Carrot's in-network providers are covered. Any treatment received from a provider not included in the Carrot network is not covered by the Health Plan.

Learn More

To learn more about the Health Plan's infertility benefits through Carrot, visit **www.dgaplans.org/infertilitybenefits**. **PH**

Be.*Well.* A new wellness series to help you Be. a better you.

Don't Confuse the Common Cold with RSV

Reading Time: 3 minutes

Fall and winter are peak seasons for respiratory illnesses, and many of us are familiar with how to treat these seasonal ailments. But when symptoms of so many respiratory illnesses all look the same, what are the signs that you should seek proper medical attention for something that could become more serious?

Symptom confusion is especially concerning for anyone who is more vulnerable to the potentially more serious illnesses like COVID and RSV, which seem to affect younger children, adults over 60 and the immunocompromised to a greater extent. If you belong to one of these groups or care for someone who does, you should become familiar with the serious symptoms of these illnesses and what actions you can take to keep you and your loved ones safe.

Distinguishing RSV from the Common Cold

Respiratory Syncytial Virus, or RSV, shares several symptoms with the common cold, including headache, low-grade fever, runny nose and cough. Both are also highly contagious and can be spread by inhalation, touching contaminated surfaces or being around someone who is infected. If left untreated, however, RSV can become much more severe, even requiring hospitalization, especially for young children and older adults.

There are three ways to distinguish RSV from the common cold:

- Wheezing and trouble breathing;
- Symptoms get worse instead of better over time (typically a week or so); and
- A blood test or mouth swab from your doctor that confirms you have RSV.

RSV Immunizations Recommended for Some; Others Should Take Precautions

This is the first season for which RSV immunization is available for groups at risk for severe RSV. The Centers for Disease Control and Prevention (CDC) recommend the vaccine for the following groups:

- **Adults ages 60 and over** should consider immunization and speak with a doctor about whether

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The Common Cold & RSV

they should get RSV vaccine. Older adults, especially those with certain underlying conditions, are at greater risk of developing complications if they were to contract RSV.

- Women who are 32-36 weeks pregnant should get RSV vaccine during RSV season, which generally runs September to January, though this might vary by area.
- Babies younger than eight months who were born during or are entering their first RSV season are recommended to receive RSV antibody immunization. Mothers who have already received the vaccine during pregnancy should speak with their doctor about whether another vaccine for the baby after birth is necessary.
- Children ages 8-19 months who are entering their second RSV season are recommended to receive the RSV antibody immunization if any of the following apply:
  - They have chronic lung disease from being born prematurely;
  - They are severely immunocompromised;
  - They have cystic fibrosis with severe disease; or
  - They are American Indian or Alaska Native (who have been shown to have higher rates of RSV when compared to other U.S. children).

The DGA–Producer Health Plan covers RSV immunization for participants and their dependents, regardless of whether you belong to one of the groups recommended for the vaccine. RSV vaccine is covered under the Health Plan's preventive care benefit, which means the co-insurance for

CONTINUED ON BACK COVER

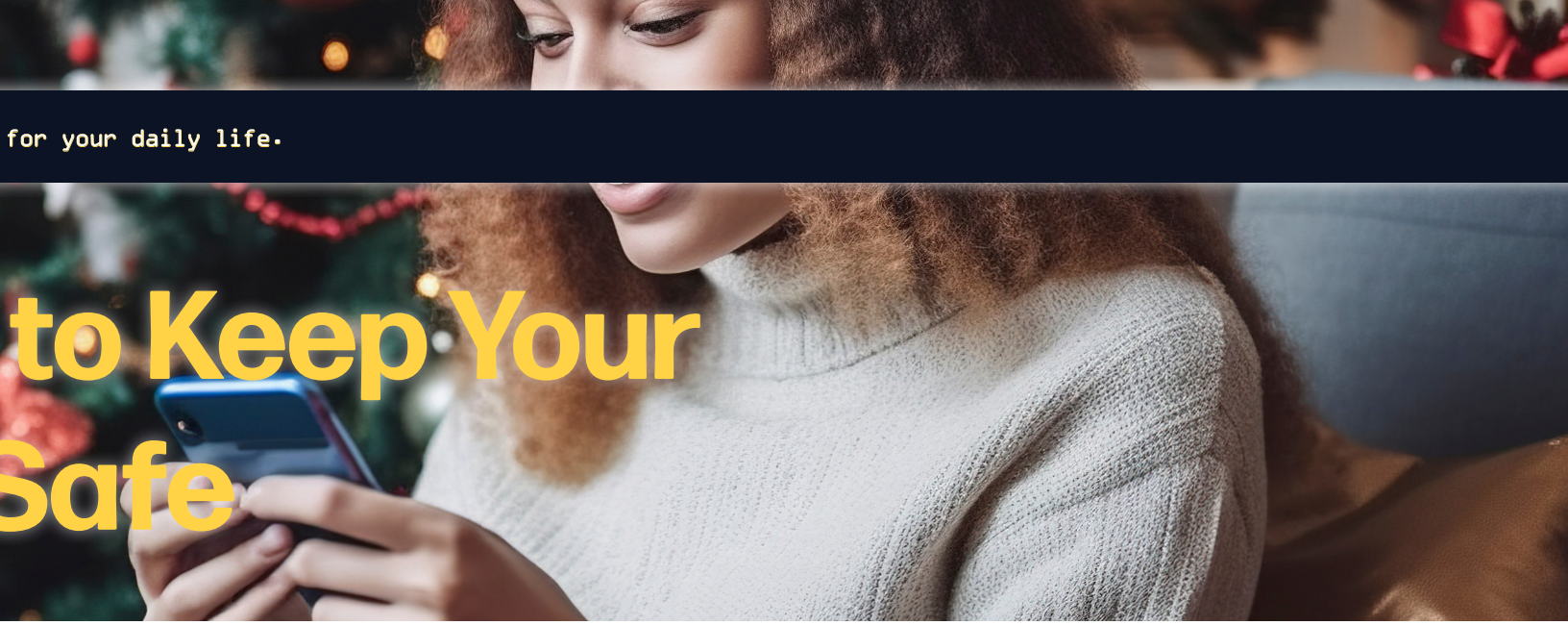
This time of year, many people find themselves unpacking the new gadgets gifted to them during the holidays. In today's world, many of those gadgets will be able to connect to the internet or to other devices to complete tasks more efficiently. But just as technology is getting "smarter," so are the cybercriminals looking for ways to exploit that technology to steal your information and wreak havoc.

As exciting as it is to get a new device, a necessary step when integrating it into your home is to protect it against these cybercriminals. This edition of the ongoing `CyberSmart(er)` series provides the following simple strategies you can use to "out hack" the hackers looking to take advantage of weakly-guarded home devices:

1. **Create a complex and unique password for your router.** Your home's router connects all your devices to the internet and often acts as a firewall to protect your home network. To protect your router, remember to:

   - Create a strong Wi-Fi password.
   - Change your router's default administrative password.
   - Change passwords periodically and whenever you think they have become compromised.

   - Create separate wireless networks for visiting guests and for specific



devices within your home to keep your main network protected in the event of a cyberattack.

- Replace your router every three to five years and keep the router's firmware up to date to ensure it has the latest security patches and safeguards.
- Turn off remote access to your router to limit a hacker's access from afar.
- Turn on router firewall and encryption settings.

2. **Do not use the default password on any new device.** It may also be the default password on a device a hacker has access to or one that they already know.
3. **Review** the list of Bluetooth and wireless connections on your devices if possible **and disconnect from unwanted or suspicious networks or devices**.
4. **Install antivirus software** on your new device and install updates whenever they are available.
5. For added protection on devices that use personal assistant services (*e.g.*, Alexa, Siri, etc.), **turn off the listening and location settings.** Do you need location services on a device that stays at home? Do you want Siri or Alexa eavesdropping on your private conversations? If you answer no to these questions, deactivating these settings is an easy way to guard more of your personal information.

6. Phishing attacks often come in the form of emails and text messages, but a computer or cellphone are not the only devices at risk. Video game systems, smart watches and the like receive messaging and chats too. **Know the signs of common phishing attacks** to avoid giving hackers access to your new devices.

7. **Use a virtual private network, or VPN,** to encrypt your data and IP address. An IP address is a device's unique identifying number and provides your device's data and location to those who have the number. A VPN on your home network will hide your device's IP addresses from criminals by encrypting these numbers and the data sent from the devices.
8. **Use two-factor authentication** to remotely access home devices that grant immediate physical or digital access to your home (*e.g.*, garage openers, security cameras, etc.).
9. Whether a new phone, pet camera, baby monitor or any other smart device, **ensure the device's software remains up to date.**

For more information on the specific vulnerabilities of common devices and how to keep them safe, visit https://foundation.mozilla.org/en/privacynotincluded/. PH

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Women's Health and Cancer Rights Notice

Reading Time: 1 minute

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 questions, please contact the Participant Services Department toll-free at (877) 866-2200, Ext. 401. **PH**

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The Common Cold & RSV

the vaccine will be paid at 100% with no deductible when received from a network provider. If you receive RSV vaccine from a non-network provider, the Health Plan will pay the usual co-insurance amount of 60% to 70% of the Reasonable and Customary Allowed Amount for the DGA Choice and DGA Premier Choice plans, respectively, after you have met your annual deductible.

RSV vaccine is available from providers and pharmacies nationwide. To schedule an RSV vaccine at a CVS Caremark network pharmacy, go to **www.cvs.com/immunizations/get-vaccinated**.

Whether or not an individual has had RSV immunization, we should all take precautions to prevent the spread of RSV and other seasonal illnesses. These include washing hands frequently, disinfecting surfaces, and covering your coughs and sneezes. **PH**