Spotlight ON BENEFITS

Volume 32, Number 3 | FALL 2024

Flu, COVID and RSV Vaccinations Are Free When Obtained In-Network. What Other Preventive Care Could You Be Getting at No Cost?

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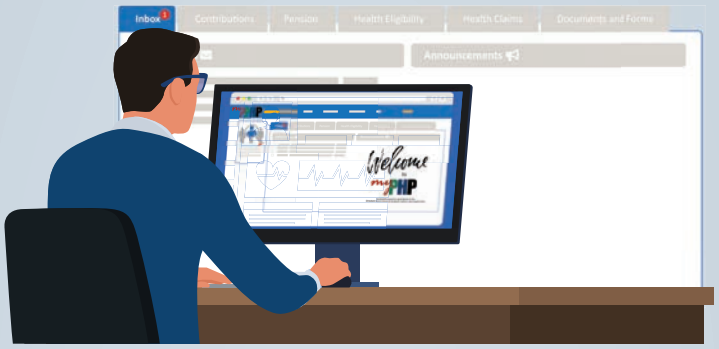
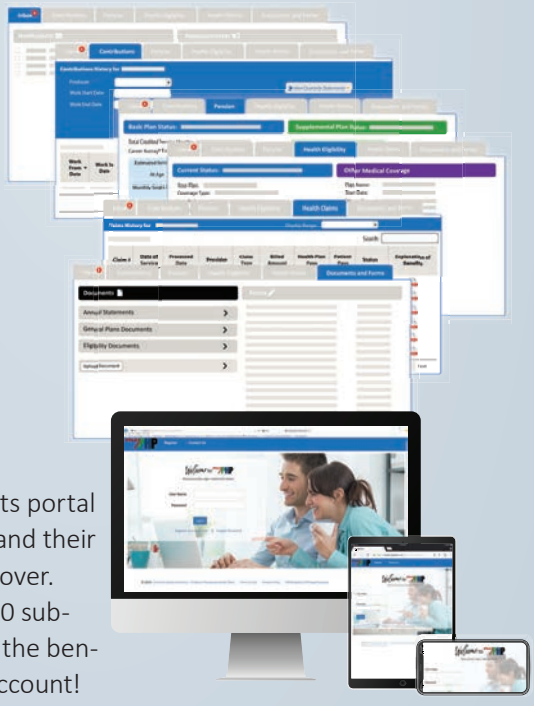
Manage Your Benefits Online with the myPHP Online Benefits Portal



The myPHP online benefits portal puts everything you need for securely managing your pension and health benefits at your fingertips. 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



The myPHP online benefits portal is free to DGA members and their dependents ages 18 and over. Join the more than 10,000 subscribers already enjoying the benefits of a myPHP portal account!

TO LEARN MORE ABOUT THE PORTAL OR TO REGISTER, GO TO:

www.dgaplans.org/about-myPHP.

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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.

Flu, COVID and RSV Vaccinations Are Free When Obtained In-Network.

What Other Preventive Care Could You Be Getting at No Cost?

Reading Time: 2 minutes

It's no secret that doctor visits can be expensive, but if your visit includes one of the more than 100 services considered "preventive" by the U.S. government (*e.g.*, a flu or COVID vaccination) and that service is rendered by a network provider, that service will be free of charge.

What are Preventive Care Services?

Preventive care services are medical services that have been proven to help people avoid chronic and acute illness. The Affordable Care Act mandates insurance plans, like the Health Plan, cover these services at 100% of the cost when administered by a network provider. The United States Preventive Services Task Force, a panel of experts in disease prevention and medicine, recommends which services should be on the U.S. preventive care list. As required by the Affordable Care Act, the Health Plan adds these services to its preventive care list within a year of the task force's recommendation.

The current preventive care list covers a range of services for all ages, including the following:

- Flu and COVID vaccinations;
- RSV vaccinations for adolescents ages 19 and under, adults aged 60+ and pregnant women
- Newborn hearing screening;
- Breast cancer mammography every two years for women aged 50 to 74 years;
- Colorectal cancer screening for adults ages 45 to 75, once every 10 years;
- Autism screening for children at 18 and 24 months; and
- Blood pressure screening for adults.

Taking advantage of preventive care services can benefit both your health and wallet. For example, the Centers for Disease Control and Prevention (CDC) notes that if the majority of U.S. adults were to follow the guidance recommended for colorectal cancer screening, deaths from the disease could be reduced by as much as 33% by 2030.

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CDC Simplifies COVID-19 Vaccination Recommendations for Those 65+ and/or Immunocompromised

Reading Time: 1 minute

COVID-19 vaccines are still considered an effective way to ward off serious illness from COVID, especially for more vulnerable groups like the immunocompromised and those ages 65 and older. To protect these groups against current strains of the virus, the CDC now recommends two doses of the 2024-2025 COVID-19 vaccine (Moderna, Pfizer-BioTech or Novavax) to be received six months apart.

For those considered moderately or severely immunocompromised—defined by the CDC as anyone having a weakened immune system due to a medical condition or who is receiving medications or treatments that suppress your immune system—the CDC recommends you consult with your healthcare provider to determine if a third dose of the 2024-2025 COVID-19 vaccine or more are needed.

NOTE: The CDC recommends that everyone stay up to date with the COVID-19 vaccination schedule. Find the most recent COVID-19 vaccine recommendations for your age group at www.cdc.gov/covid/vaccines/stay-up-to-date.html.

For participants covered under the Health Plan, COVID vaccinations are covered at 100% under the Affordable Care Act's preventive care benefits if administered by a network provider or network pharmacy. To schedule a COVID vaccination at your local CVS Caremark pharmacy, visit www.cvs.com. PH

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Preventive Care Services You Could be Getting at No Cost

Improve Your Health and Keep Track of the Recommended Preventive Care Services

Below are some tips to follow to enhance your health and ensure you are following the recommended guidelines:

1. When seeking preventive care, make an appointment for your desired preventive services with a network provider; and
2. Keep a calendar or journal that documents when your preventive services were last completed and when it is recommended you complete them again.

Keep in mind preventive services that are not within the required guidelines or provided by a non-network provider will not be paid at 100%. For questions about the timing of preventive services or your potential costs, contact the Health Plan's Participant Services Department at 323-866-2200, Ext. 401.

Takeaways

Following the recommended guidelines for preventive care services can help you enhance and maintain your health. Flu and COVID vaccinations, health screenings and many other preventive services are provided at no cost to you when administered by a network provider. Familiarize yourself with the full list of free preventive care services available to you by visiting www.dgaplans.org/preventivecare. PH

HOW TO GET YOUR BENEFITS CARDS

Reading Time: 1.5 minutes

Benefits cards provide proof of coverage and essential information about your benefits. To access these cards online or on your mobile device, follow the steps below.

NOTE: Online benefits card access requires that you create a login with the applicable benefit partner. **PH**

BENEFIT PARTNER	INSTRUCTIONS FOR COMPUTER	INSTRUCTIONS FOR MOBILE DEVICE (Apps are available at the app store for your device.)
Anthem **NOTE:** Dependents on your plan are not issued an ID card and must use a copy of your card when accessing care.	1. Visit www.anthem.com/ca. 2. Click dropdown arrow under Member Support. 3. Select Get An ID Card. 4. Log in to your account. 5. Select how you would like to access your card (*e.g.*, email, mail, download, etc.).	1. Log in to the Sydney Health mobile app. 2. Select the ID Cards button. 3. Choose if you would like to download, share (mail, email or fax) or add your card to your mobile wallet.
DELTA DENTAL **NOTE:** Delta Dental issues cards for participants only. Your dependents should use a copy of your card.	1. Visit www.deltadentalins.com. 2. Log in to your account. 3. Select Get ID card. 4. Show or print your ID card.	1. Log in to your Delta Dental mobile app. 2. Your Delta Dental membership card will appear in the center of the mobile app Welcome screen. See below the card for options like emailing the card, saving it to your mobile wallet, etc.
CVS caremark® **NOTE:** Neither the CVS retail app nor CVS Specialty app offer automatic prescription card access. Automatic card access is only available with the CVS Caremark mobile app.	1. Visit www.caremark.com. 2. Log in to your account. 3. Select Get ID card. 4. Show or print your Member ID card.	1. Log in to your CVS Caremark app. 2. Select View I.D. Card. 3. Show, print or add your card to mobile wallet.
vsp VISION	1. Visit www.vsp.com. 2. Select Member ID Card. 3. Save, print or email the card.	1. Log in to the My VSP mobile app. 2. Tap Member ID Card. Your coverage card will be displayed on screen. 3. Scroll down for options for downloading or emailing the card.

Are You Receiving Outpatient Mental Health, Su Physical Therapy Treatments? Learn How the He These Treatments.

Reading Time: 4.5 minutes

The Health Plan covers visits for outpatient mental health, substance abuse and physical therapy services with no preauthorization required, as long as the services are considered Medically Necessary under the terms of the Plan. However, because a typical course of treatment for these services might continue over an extended period of time, the Health Plan has established procedures (referred to as the "20/30 visit" procedures) for evaluating the Medical Necessity of ongoing treatment. The Health Plan has been applying these 20/30 visit procedures for many years, and you may already be familiar with them.

Under the Health Plan's 20/30 visit procedures, all participants and beneficiaries must demonstrate that ongoing treatment for mental health, substance abuse or physical therapy beyond 30 visits is Medically Necessary. As a courtesy, the Health Plan will send notification to participants and beneficiaries after receiving the 20th claim for a single course of treatment to remind them that they must demonstrate Medical Necessity for ongoing treatment after the 30th visit to be covered. **NOTE:** The Health Plan may confirm Medical Necessity for a service or course of treatment prior to the 31st claim.

Recently, the Board of Trustees amended the Health Plan's Summary Plan Description ("SPD") to add a description of the 20/30 visit procedures in order to help ensure that participants are aware of the process when receiving these types of treatments.

For further details, please refer to the newly added explanation of the 20/30 visit procedures in Article IV, Section 11 of the March 2020 Health Plan Summary Plan Description at www.dgaplans.org/health-plan-booklet, or contact the Health Plan for a hard copy to be sent to you at no cost.

The 20/30 Visit Procedures

The 20/30 visit procedures help the Health Plan determine when continued visits for an ongoing course of treatment are Medically Necessary, and therefore, eligible for continued coverage.

1. **Claims for visits 1-19.** You are receiving outpatient mental health, substance abuse or physical therapy services as part of a single course of treatment. If claims have been filed timely and all other requirements for Plan coverage—including Medical Necessity—are met, these visits would normally be covered.

Substance Abuse or Health Plan Covers

2. **Claim for visit #20.** The Health Plan notifies you and your doctor that, at 30 visits, your medical records will need to be provided for review to confirm the Medical Necessity of continued treatment. The Health Plan can also arrange for a peer-to-peer review to discuss Medical Necessity directly with your provider. At this point, the Health Plan continues covering treatment.

3. **Claim for visit #30.** The Health Plan sends you and your doctor a notice requesting medical records for review to confirm the Medical Necessity of continued treatment beyond 30 visits.

4. **Claims for visit #31+.** The Health Plan will deny coverage on subsequent claims after the 30th visit, pending the Health Plan's receipt of the requested records and review an approval for Medical Necessity. You are encouraged to work with your provider to ensure that the requested information is submitted to the Health Plan in a timely manner and no later than 180 days from the date of the notice. The Health Plan can also arrange for a peer-to-peer review to discuss Medical Necessity directly with your provider. The results

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

Reading Time: 1 minute

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 determines how much you pay out-of-pocket for services—the term "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:

- ☑ 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;
- ☑ Ordered by the attending licensed physician or dentist and not solely for your convenience, your physician, hospital or other healthcare provider;
- ☑ Consistent with professionally recognized standards of care in the medical community with respect to quality, frequency and duration; and
- ☑ 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.

A treatment, service or supply must satisfy all of the criteria above to be considered Medically Necessary under the terms of the Health Plan. 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. PH

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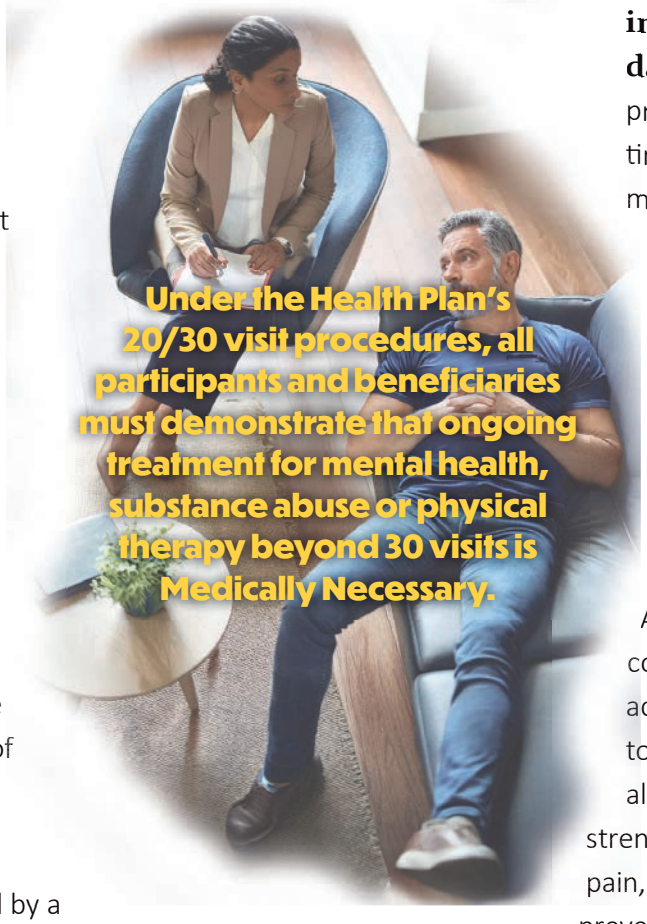
How the Health Plan Covers Outpatient Treatments for Outpatient Mental Health, Substance Abuse or Physical Therapy

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.

Important Considerations to Keep in Mind

- **File claims timely.** 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. If your provider is a non-network provider and you are submitting claims for reimbursement, it is best not to wait and file claims in bulk, as you may find out after the fact that your claims are determined to be not Medically Necessary. You are responsible for the full cost of any claims determined to be not Medically Necessary.

  If your treatment is rendered by a network provider, who will typically file claims on your behalf, use your myPHP benefits portal account (www.dgaplans.org/about-myphp) to monitor whether your claims are being filed timely. As your claims are processed, you should receive the corresponding explanations of benefits ("EOB") in the Health Eligibility tab of your myPHP account. Although non-network providers must submit claims within one year of the date of service, and network providers must submit claims within the timeframe defined in their contracts, if you find that your EOBs are taking too long to appear in your myPHP account, contact your provider to verify that they are submitting your claims timely (and not waiting to submit them in bulk).



- **Respond to Health Plan requests for information by the date requested.** Failure to provide required information timely will result in automatic denial of claims under review, pending receipt of information sufficient to confirm Medical Necessity.

- **Maintenance programs are considered not Medically Necessary.** A maintenance program consists of treatments or activities that are intended to preserve the individual's present level of range, strength, coordination, balance, pain, activity, function, etc., and prevent regression. 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.

- **The Health Plan is not prohibited from confirming Medical Necessity for the duration of a service or course of treatment prior to the 31st claim.** This includes courses of treatment of unusual or irregular duration, frequency or scope of services provided over a period of time.

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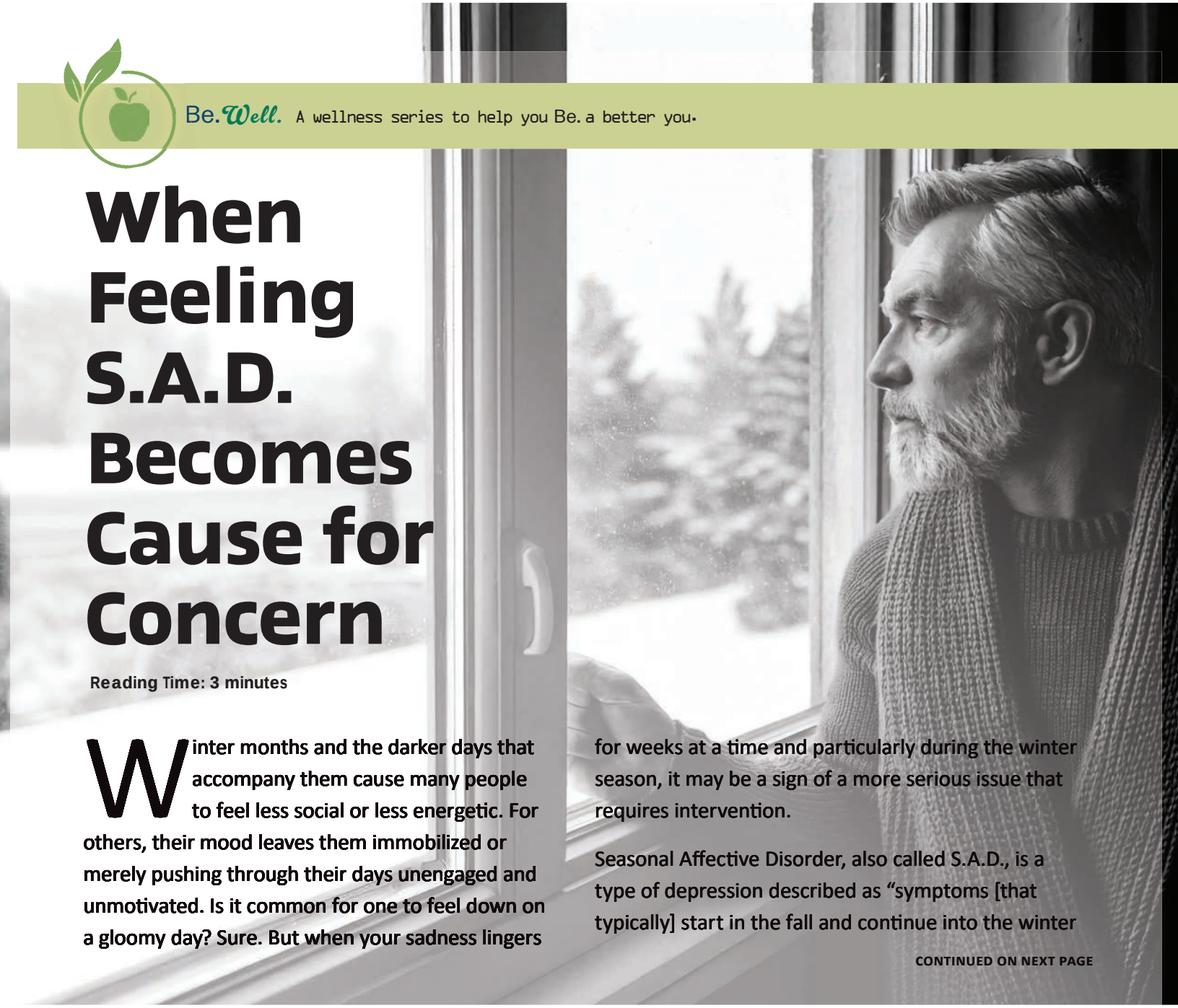
When Feeling S.A.D. Becomes Cause for Concern



Reading Time: 3 minutes

Winter months and the darker days that accompany them cause many people to feel less social or less energetic. For others, their mood leaves them immobilized or merely pushing through their days unengaged and unmotivated. Is it common for one to feel down on a gloomy day? Sure. But when your sadness lingers for weeks at a time and particularly during the winter season, it may be a sign of a more serious issue that requires intervention.

Seasonal Affective Disorder, also called S.A.D., is a type of depression described as "symptoms [that typically] start in the fall and continue into the winter

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How the Health Plan Covers Outpatient Treatments for Outpatient Mental Health, Substance Abuse or Physical Therapy

- **When in doubt, contact the Health Plan.** If you are undergoing treatment for physical therapy, mental health or substance abuse and have surpassed 20 visits with no request for further information from the Health Plan, you are encouraged to contact the Health Plan Participant Services Department at (323) 866-2200, Ext. 401, to check where you are in the 20/30 visit evaluation process or for any other information regarding your claims status. PH

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Feeling S.A.D.

months, sapping your energy and making you feel moody." Those who suffer from this disorder may experience general symptoms of depression combined with additional symptoms specific to S.A.D. Some of the most common symptoms include the following:

- Oversleeping;
- Low energy;
- Hopelessness;
- Difficulty concentrating;
- Overeating and weight gain; and
- Persistent sadness.

Why Does S.A.D. Happen?

According to the National Institute of Mental Health, S.A.D. occurs due to changes in the number of daylight hours to which a person is exposed, which is why this form of depression is more common in the fall and winter months. Although researchers are still uncovering information about the disorder, studies show that those who suffer with S.A.D. experience decreased levels of the brain chemical serotonin, the body's "feel good" chemical, as well as a decrease in Vitamin D, which promotes serotonin. Both are partially responsible for regulating mood.

Decreased serotonin along with additional factors like decreased levels of melatonin, disruptions to circadian rhythm, and/or histories of depression or bipolar disorder can also contribute to experiencing S.A.D. or can put someone at higher risk for developing it.

Although this disorder cannot be prevented, people who consistently experience these symptoms should contact a healthcare professional to learn about ways to manage them and prevent symptoms from worsening.

What to Do About S.A.D.

S.A.D. should be diagnosed only by a healthcare provider or mental health specialist. All Affordable Care Act-compliant insurance plans—including the Health Plan—are required to cover depression screenings at no cost to the patient when provided by a network doctor.

Once diagnosed with S.A.D., treatment options are vast. For those who suffer from winter S.A.D., the most common treatments include various forms of therapy and medication.

Common Treatments for S.A.D.

Light therapy This is where a patient exposes themselves for at least 30 minutes a day to a light box that contains a very bright light that mimics natural sunlight.

Cognitive behavioral therapy A study published in the American Journal of Psychiatry found that just six weeks of this therapy decreased symptoms of depression for adults.

Antidepressant medication

Alarm clocks that function as dawn simulators

Consistent sleep schedule

Socializing with loved ones

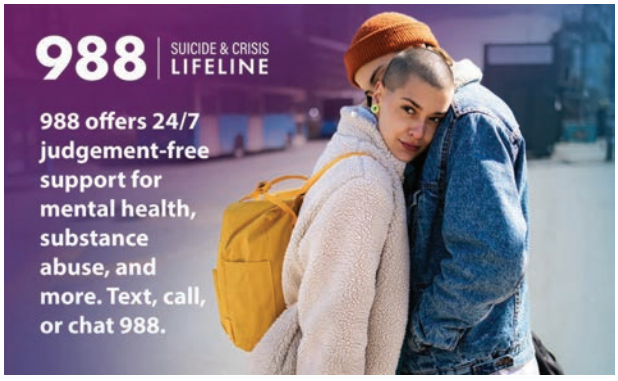
Exercise Research shows that exercise and socializing may relieve S.A.D.

Additional Resources

Seasonal Affective Disorder is more than just feeling a bit down because of the weather. It is a type of depression that if left untreated can increase in severity, especially for those who suffer from additional mental health disorders.

If you or someone you know appears to be in immediate danger, call 911. To locate a healthcare provider or mental health support, see the resources listed below:

- **DGA-PPHP Health Plan's Find a Network webpage** https://www.dgaplans.org/find-a-network-provider
- **Substance Abuse and Mental Health Services Administration's Online Treatment Locator** https://findtreatment.gov/
- **988 Suicide and Crisis Lifeline** call or text 988 or chat at https://998lifeline.org **PH**



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