DGA-PRODUCER PENSION & HEALTH

Spotlight ON BENEFITS

FALL 2017

TOP 6 THINGS TO LOOK OUT FOR WHEN SUBMITTING YOUR CLAIMS

Learn the six most common reasons medical claims get denied so you can avoid them.

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Considering taking a benefit from the Basic or Supplemental Pension Plan? Here are steps you should take.

There's much to think about before you make the decision to start taking your pension benefits. You may have many questions on your mind. Of course, like many important decisions we have to make in our lives, they must be carefully planned. From accumulating enough assets for your needs to submitting your benefit application, certain things must be in place to ensure taking your pension benefits goes smoothly.

To give you an idea of what you should do and when, use the timeline and checklist on page 5 as a guide. Though much of it refers to steps you must take before requesting a pension benefit, your plans for after you start receiving you pension benefit are just as important, especially if you intend to work in a DGA-covered capacity while receiving a monthly benefit from the Basic Plan.

For general information about participating in the pension plans and qualifying for benefits, visit www.dgaplans.org/pensionplans. For more personalized assistance and to obtain an estimate of your benefit payments, contact our Pension Department at (877) 866-2200, Ext. 404 or pension@dgaplans.org. You can always schedule a one-on-one meeting via Skype or in person with a Pension Plan representative.

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COMING IN OCT! Annual Health Fairs and Flu Shot Clinics

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

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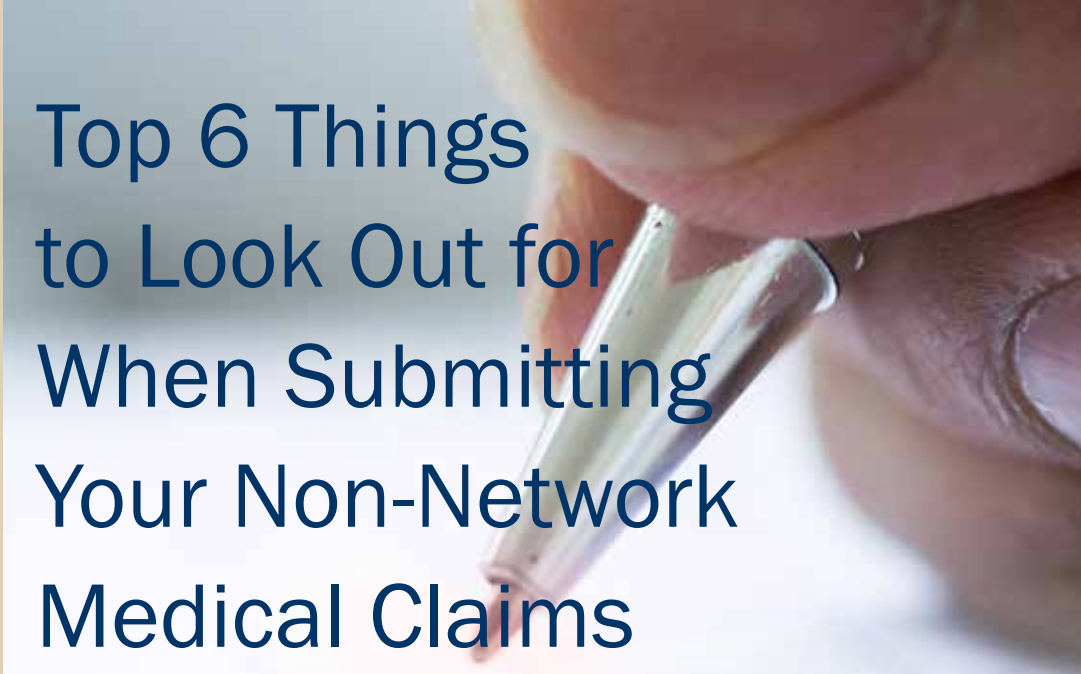


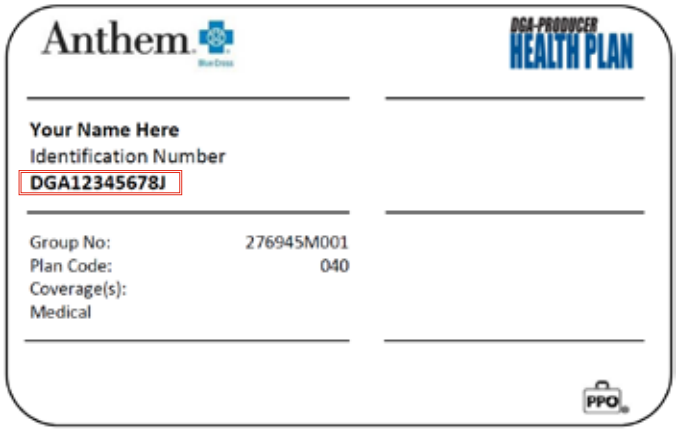
Top 6 Things to Look Out for When Submitting Your Non-Network Medical Claims

Every year, some medical claims submitted by Health Plan participants cannot be processed due to incomplete or illegible information, missing or unacceptable documentation or submission to the wrong address. These claims are usually denied. Though denied claims can be reprocessed, this can be avoided by ensuring that each of your claims includes all the necessary information for the Health Plan to process it timely and without incident.

Below are six common reasons claims are denied and strategies for how to avoid them. The next time you or your dependent submits a claim, be sure to have this list handy to avoid these pitfalls.

#1 Incorrect or Incomplete Health Plan ID number

Your Health Plan ID number is not the same as your DGA member number. Your Social Security number is also not acceptable. The identification number required on your medical claim forms is the ID number listed on your Health Plan ID Card or in the top right corner of most correspondence the Health Plan sends you. When filling in your identification number on your claim form, be sure to include the DGA (at the beginning) and the J (at the end). If you complete your claim form online at dgaplans.org/forms/health, the DGA and J are pre-filled for you. See the example below for the location of your ID number from your Health Plan ID Card.



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#2 Illegibly Completed Information

All information requested on the claim form is essential for processing. Information that cannot be read will result in your claim being denied. To avoid this situation, it is best to complete your claim form online at dgaplans.org/forms/health. If you must hand write your claim forms, be sure to print clearly, write in ALL CAPS and use blue or black ink.

#3 Missing or Outdated Group Number

All Health Plan participants have a group number beginning with 276945M that is provided on the front of your Health Plan ID card. Be sure to include your entire 10-digit group number on each claim form you submit. If you are completing your claim form online, the first 7 digits of the group number are completed for you.

Additionally, because your group number changes according to the type of coverage you have, it is important you use the group number from your most recent Health Plan ID card.

#4 Missing Patient and/or Subscriber Information

Both patient AND subscriber (or participant) information must be completed in their entirety on each claim form, even if the patient and subscriber are the same person. Each of these sections provides different, essential information for claims processing. Filling in one section and writing "same" or "same as above" for the other will be considered incomplete, and your claim will be denied.

#5 Unacceptable Receipts

You must include an itemized bill with each claim form you submit, and that bill must include ALL of the following required information:

- Name and address of the provider
- Name of the patient
- Description of service provided
- Date of service
- Place of service
- Amount charged for each service
- Diagnosis code
- Procedure code
- Provider Tax ID

Credit card receipts, balance due statements and cancelled checks do not include the required information and, therefore, are not acceptable.

#6 Missing Attachments

If you and/or your dependents have primary coverage with another insurer, each claim submitted for the person with dual coverage must include the explanation of benefits from their primary insurer for that same claim. This explanation of benefits should detail how the primary insurer processed the claim.

Additionally, each year you have Health Plan coverage, you must submit a new Coordination of Benefits Form, verifying whether or not you and/or any of your dependents are eligible for coverage from another insurer. For example, if you have a spouse whom you cover as a dependent but who is also eligible for coverage through his or her employer, this information must be reported on the Coordination of Benefits Form on a yearly basis. Without a current Coordination of Benefits Form on file, your claims and those of your dependents may be automatically denied until a current form is submitted. A Coordination of Benefits Form is included in the open enrollment packet you receive at the beginning of each benefit period. Whenever you receive this form, you should complete and return it even if you feel you have done so previously and even if the information has not changed.

In summary, submitting claim forms that are completely and legibly filled out and supported by acceptable documentation is the best way to avoid unnecessary processing delays and denials. Using the online claim form available at dgaplans.org/forms/health is one easy way to solve many common claims issues. After completing your form online, you can print it from your computer and attach your itemized bill before sending it to the appropriate location. Once received, you can check the status of your claim online at the Anthem Claims portal at anthem.com/ca. (Registration required.) Claims filed by any non-network providers must be submitted within one year from the date of service.

For help with your claims questions, call Participant Services at (877) 866-2200, Ext. 401. **PH**

Live outside the U.S.?
Looking for benefits information?

Visit our
Non-U.S. Participants
information pages at
www.dgaplans.org/nonus

Taking Care of Your Teeth at Every Age

Most of us will have two sets of teeth during our lifetime—our baby teeth that are normally lost by age 12–13 and our adult teeth that we keep for the remainder of our lives. Brushing and flossing are the most consistent ways to protect oral health no matter what your age, but each stage of life also presents unique challenges you should be aware of and on guard against. Good dental habits mean different things at different ages.

Birth to Age 12

You may think of the period before you get your adult teeth as a less important time for oral care, but this is not the case. Not only are oral health habits established most firmly during this time, but it is also when dental care has the greatest implications for later in life. Follow the tips below to make sure your babies, children and adolescents are poised for better dental health well into adulthood:

- Clean and massage your baby's gums every day.
- Avoid prolonged thumb or pacifier sucking to ensure proper tooth growth and alignment.
- Start brushing your child's teeth as soon as they appear.
- Remove baby's bottle before bedtime to keep acids produced by the bacteria that feed on juice or milk from attacking your baby's tooth enamel.
- Help children begin brushing on their own at age 2

Teenagers

Teenagers are probably at highest risk of unexpected oral accidents due to sports injuries and mishaps that cannot be planned for. Follow these tips to help keep teeth and gums healthy against the issues that can be prevented:

- Visit the dentist regularly.
- Choose healthy foods like milk, fruits and vegetables instead of soda and sugary foods.
- Wait until at least age 14 to begin teeth whitening.
- Take extra care to clean food and plaque that can become trapped in braces and wires.
- Know the dangers of tongue piercing.
- Wear proper mouth guards when playing sports.

Older Adults

Even the most diligent brushers and flossers may have specialized oral health needs as they age. Many older adults have other conditions or take medications that affect their oral health. Follow the tips below to make sure your teeth and mouth remain as healthy as possible:

- Keep visiting your dentist regularly to keep abreast of signs of gum disease and oral cancer.
- Prevent or treat dry mouth caused by some medications as saliva plays a major role in preventing tooth decay.
- Inform your dentist of changes in your medications as some medicines interact with dental anesthesia or change oral tissue.

Taking care of your oral health is a lifelong habit that should begin early. Be sure to keep these tips in mind as you care for your teeth and those of your children. **PH**

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Steps to Consider Before Taking Your Pension Benefits

6-12 Months

Before Your Benefit Start Date

- Plan and research your benefit options and eligibility
- Contact the Plans for a personalized benefit estimate
- Decide on your desired date to start taking your pension benefits
- Consult with a financial advisor to ensure you understand the pros and cons of the various benefit options and tax consequences, as your benefit election cannot be revoked once benefits begin.

3-6 Months

Before Your Benefit Start Date

- Contact the Plans to receive assistance with planning your benefit distributions. You can schedule a one-on-one meeting via Skype or in person by calling us (877) 866-2200.
- Gather required documents (*e.g.*, proof of birth, proof of marriage, proof of divorce). If you believe these documents are already on file with the Plans office, call us at (877) 866-2200 Ext. 404 to confirm.

60-90 Days

Before Your Benefit Start Date

- Submit a Retirement Application Request Form at least 60 days prior to your intended benefit start date.

30 Days

Before Your Benefit Start Date

Basic Plan	Supplemental Plan
▶ Submit your completed Basic Plan application and any required documentation by the 15th of the month prior to your intended benefit start date. *If you would like your Basic Plan benefit to commence June 1st, your application must be received no later than May 15th.*	▶ Submit your completed Supplemental Plan application and any required documentation by the last day of the month prior to your intended benefit start date. *If you would like your Supplemental Plan benefit to commence June 15th , your application must be received no later than May 31st.*

Benefit Start Date

Basic Plan	Supplemental Plan
▶ Your Basic Plan benefit commences on the first of the month.	▶ Your Supplemental Plan benefit commences on the 15th of the month.

After Your Benefit Start Date

Basic Plan	Supplemental Plan
▶ Submit an Employment Recap Form to the Plans office whenever you return to employment in your DGA-covered capacity for 8 or more days during a calendar month (only required if you are receiving a monthly Basic Plan benefit).	▶ Unlike the Basic Plan, your Supplemental Plan benefits will not be suspended if you return to work. ▶ Complete a Post-Retirement Distribution Application Request Form to make changes to the amount and/or frequency of any partial distributions. ▶ You can roll over funds into the Supplemental Plan at any time. ▶ Update your beneficiary information.

By April 1st of the year following the year in which you turn 70 1/2, if you haven't already done so, you will be required to commence your Basic Plan and Supplemental Plan benefits and take a Minimum Required Distribution in accordance with Plan rules and federal regulations. PH

Updated Anthem Blue Cross Required Disclosure for Inter-Plan Agreements

Anthem Blue Cross, the Health Plan's medical provider network, maintains agreements with providers of health-care services outside the geographic areas Anthem serves so covered Health Plan participants can access non-network medical services anywhere in the world. Below is an updated description of those arrangements.

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area Anthem serves (the "Anthem Service Area," which includes California, Colorado, Nevada, Kentucky, Indiana, Ohio, Missouri, Wisconsin, and Georgia), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("non-participating providers") don't contract with the Host Blue. The following explains how claims are processed for both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive services covered by the DGA-Producer Health Plan, or "Covered Services," within the geographic area served by a Host Blue, Anthem will still fulfill its contractual obligations. The Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or under-estimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Anthem used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through negotiated arrangements for national accounts.

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Required Anthem Disclosure

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments.

If Anthem has entered into a negotiated arrangement with a Host Blue to provide value-based programs to the Plan on your behalf, Anthem will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard Program.

D. Non-participating Providers Outside Anthem Service Area

The pricing method used for non-participating provider claims is described in the DGA-Producer Health Plan SPD on page 36 under Article IV, Section 1(g): Health Plan Terms/Reasonable and Customary Charge.

E. Blue Cross Blue Shield Global Core Program

If you plan to travel outside the United States, call customer service to find out your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center at any time. It is available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call collect at 804-673-1177.

How claims are paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors' services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core claim forms, you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.
- On the DGA-Producer Health Plan's website at https://www.dgaplans.org/nonusclaims.

You will find the address for mailing the claim on the form. PH

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The Directors Guild of America - Producer Health Plan does not discriminate on the basis of race, color, national origin, sex, age, or disability.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-866-2200.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-866-2200. PH

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Health Fairs this Fall in LA & NYC

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

Los Angeles

October 7

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

New York City

October 21

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

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

Free Flu Shots. **Reservations required. RSVP to FluShots@dgaplans.org or at (323) 866-2216.** Flu shots are available to all DGA members and their dependents age 13 and over. Women who are pregnant or nursing cannot be given the flu shots and should check with their OB-GYN for more information. The DGA Foundation is covering the cost of flu shots for participants not covered under the Health Plan.

Benefits Information. The Pension and Health Plans' staff, along with representatives from Express Scripts, Delta Dental, and Vision Service Plan, will be onsite to provide information on the diverse benefits available to participants and DGA members. In Los Angeles, UCLA Health/MPTF will also be onsite to answer questions.

New for 2017. A Medicare presentation specifically for Members who are Medicare eligible or approaching Medicare eligibility. Get information on how Medicare works with DGA Health Plan coverage, when to begin Medicare enrollment and more.

Actors Fund Seminar. For those not covered by the Health Plan, a presentation will be given on the state's Health Insurance Marketplace.

Free neck and shoulder massages

Raffle prizes and giveaways, including a chance to win a new Apple Watch!

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