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BENEFIT IMPROVEMENTS & MODIFICATIONS

Recently, the Board of Trustees approved a number of changes and clarifications to the Writers' Guild-Industry Health Fund (the "Fund"). These changes reflect improvements in administration, increases in certain benefits, clarifications of existing provisions, and new limitations. The world of health care coverage is changing daily and we hope you will recognize our effort at expanding benefits and making the reimbursement process easier for you, while understanding the need to increase certain costs and impose certain limitations.

Set forth below is a table of contents with brief descriptions of these changes. More detailed descriptions follow. Except as noted below, all of these changes are effective April 1, 2002.

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1. Increase in Pharmaceutical Copayments.

Prescription drugs – second only to medical services as the greatest cost component at the Fund – have been increasing 20% or more per year, and represented 21% of our 2000 medical-related expense budget (up from 15% of our budget in 1995). If allowed to remain unchecked, pharmaceutical costs would threaten other benefits, from hospital coverage to mental health. To compound matters, member copayments have stayed the same since 1992; the Fund now pays 91% of each filled prescription, a figure that is increasing every day. (Compare this to the 85%/15% balance between Fund and member when a member sees an in-network doctor.)

To help bring the situation under control and to preserve the financial soundness of the Fund, the Fund Trustees have developed a two-front approach: 1) negotiating with major pharmaceutical companies to buy dozens of commonly-used prescription drugs at a discounted price; and 2) striking a fairer balance between the Fund and participant in

<u>Drug Status</u>	<u>Current copayments</u>	<u>New copayments effective April 1, 2002</u>
Generic	\$3.00 – 60 day supply	\$5.00 – 30 day supply
Preferred Brand	\$8.00 – 60 day supply	\$10.00 – 30 day supply
All Other Brands	\$8.00 – 60 day supply	\$16.00 – 30 day supply
Mail order – Generic	\$0.00 – 90 day supply	\$10.00 – 90 day supply
Mail order –		
Preferred Brands	\$0.00 – 90 day supply	\$20.00 – 90 day supply
Mail order –		
All Other Brands	\$0.00 – 90 day supply	\$26.00 – 90 day supply

sharing these increased cost burdens.

There will now be three categories of prescription drugs - generic ~~drugs~~, ~~preferred brand drugs~~, and all other brand drugs – and the copayment differs for each of them. By using a generic drug or a preferred brand drug when available, you will lower your copayment. Effective April 1, 2002, the copayment rates for pharmaceuticals will change as noted in the chart above.

Please note that the copayment is based on the drug you actually receive. Thus, for example, if you receive a brand drug, even if your doctor prescribes the drug “dispense as written,” you will be responsible for the brand drug copayment, rather than the

generic or preferred brand copayment. More information regarding prescription drug coverage will be sent to you.

2. Claim Forms. Effective January 1, 2002, we have revised the claim form procedure to make submitting claims easier. You will no longer be required to file different forms for medical, vision and wellness claims. Instead, you may assign your benefits to your provider and have the provider submit the claim to the Fund directly (either electronically or in paper form). This means you will not have to pay the provider the full cost of coverage and then seek reimbursement from the Fund. You can pay the copayment, deductible, or other applicable charge and then have

1 Preferred brand drugs are brands that appear on the AdvancePCS Performance Drug List (PDL), which identifies preferred choices in selected drug categories. These preferred drugs are clinically equivalent to other brand name drugs in the same category and provide an effective alternative for many patients at a reduced cost. To obtain a copy of the PDL, you may visit www.AdvanceRX.com (select "RxFormulary," then select "2002 AdvancePCS Performance Drug List") or call AdvancePCS member services (1-800-966-5772). AdvancePCS administers prescription drug coverage provided by the Fund.

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the provider seek payment from the Fund. Alternatively, if you prefer, you may continue to pay your providers and then submit an itemized bill to the Fund for reimbursement.

To summarize, you may submit claims to the Fund Office or simply assign your benefits to the provider.

3. Identification Card. You will no longer have to carry multiple identification cards. Within the next few months you will receive ONE new health identification card to replace your current Fund identification cards for each eligible dependent. At that time, you will also receive an enrollment form. This form should be completed and returned to the Fund Office by April 30, 2002. You will receive a new enrollment form annually as long as you are eligible for coverage under the Fund.

4. Case Management. The Fund offers Case Management as a voluntary, and often valuable, program to facilitate your care and provide a treatment program that may be beneficial to you and the Fund. We are proud to announce that we have a new Case Manager, Judy Maller R.N, on staff. If you or a covered dependent experiences a major

illness or injury, such as a stroke, you may be contacted to ask if you wish to have your care and recovery monitored by Case Management, always in cooperation with your doctor. When appropriate, Case Management may recommend alternatives to the traditional hospital setting or may assist you in receiving coverage beyond certain caps and maximum allowances. These services can make your recovery more comfortable and less costly. Please note, however, that Case Management does not provide an exception to the services that are specifically excluded by the Plan.

5. Vision Coverage. Effective April 1, 2002, the Fund will pay the 85% reimbursement rate for *all* vision providers up to the annual maximum of \$325 for vision benefits. There will no longer be a network for vision coverage. Before, the Fund provided an 85% reimbursement rate for network providers and 75% for non-network providers. You may assign your benefits to the provider at the time of service and have the provider bill the Fund directly or you may submit an itemized bill to the Fund Office requesting reimbursement.

Note: As before, Lasik eye surgery is not a covered benefit.

6. Extension of Coverage After Active Participant's Death. Currently, if an active Participant dies prior to age 60 and has accumulated at least 68 quarters of eligibility, his or her surviving spouse or same sex domestic partner is eligible to remain covered by the Fund at no charge for five years. Effective April 1, 2002, if an active Participant had at least 68 quarters of eligibility and was married or in a same sex domestic partnership for two or more years at the time of death, the surviving spouse or same sex domestic partner will have a choice regarding survivor coverage. These surviving spouses and same sex domestic partners may choose (1) five years of coverage at no charge **or** (2) lifetime coverage under the Fund beginning on the date the deceased Participant would have turned age 60.

Please note that both options are subject to early termination rules. Under the five-year election, coverage will terminate early if the survivor remarries or enters a new same sex domestic partnership or becomes eligible for Medicare or another group health plan. Under the lifetime election, coverage will terminate early if the survivor remarries or enters a new same sex domestic partnership. Addi-

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tionally, under the lifetime election, once the survivor becomes eligible for Medicare, the Fund will be secondary to Medicare.

7. Eyeglasses or Contact Lenses Following Cataract Surgery. We have added a new benefit for Participants who have cataract surgery. Effective April 1, 2002, the medical plan will now cover the first pair of standard glasses or contact lenses prescribed by a doctor within the initial 6-month period after cataract surgery. Thus, these glasses or lenses will not reduce the annual \$325 maximum vision allowance under the Fund.

8. Speech Therapy Benefits. Effective April 1, 2002, speech therapy benefits will be modified in various ways. First, the Fund includes benefits for a speech impairment in a child with a well-defined articulation disorder, as determined by a licensed speech pathologist. Second, effective for visits on or after April 1, 2002, speech therapy benefits will be limited to 100 visits per calendar year; visits during the first three months of 2002 will not count against this limit.

Finally, speech therapy benefits must be coordinated with speech therapy benefits provided through your child's school. This means if

a doctor prescribes more than one speech therapy visit per week, you must provide satisfactory proof to the Fund Office that you have applied for the federally mandated individual education program (IEP) benefit through your child's school. (Please contact your child's school to learn more about its IEP program.) Any sessions covered through a school program will reduce, on a one for one basis, the 100 visit per calendar year limit paid by the Fund.

9. Air or Sea Ambulance. Currently, the Fund covers air or sea ambulance services if approved by Case Management after the bill is submitted. Effective April 1, 2002, the Fund will provide air and sea ambulance coverage up to a maximum of \$2500. If the costs exceed \$2500, the Fund Office may approve the additional costs, taking into account all of the facts and circumstances.

10. Skilled Nursing Facilities. Generally, the Fund does not provide coverage for skilled nursing facilities. However, such coverage may be available through Case Management. In order to help clarify when Case Management may authorize coverage for a skilled nursing facility, effective April 1, 2002,

the Fund language is revised to provide that Case Management may authorize coverage for a skilled nursing facility if it will benefit you and the Fund, and satisfies each of the following requirements:

- The illness is severe enough to require constant or frequent skilled nursing care on a 24-hour basis and/or while receiving rehabilitative services daily (five days per week) which cannot be safely, efficiently, or effectively provided on an outpatient basis; and
- There is an expectation of sufficient improvement in the patient's condition within a reasonable period of time that would permit the patient to be discharged to home with minimal patient services.

11. Comprehensive Medical Rehabilitation Hospital. Comprehensive medical rehabilitation hospitals are licensed and certified facilities that provide special rehabilitative health care services rather than general medical and surgical services. Rehabilitative therapy focuses on restoring physical function and abilities lost due to an acute debilitating condition. At the onset of therapy it is assumed there is a reasonable expectation

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of complete or partial restoration of function. In order to clarify the standards governing such coverage, the Plan is amended effective April 1, 2002, to provide that coverage for an admission must meet the following requirements:

- The patient has a condition that has resulted in a significant decrease in functional ability; and
- There is a reasonable expectation that the patient will improve in a reasonable and generally predictable period of time and that such recovery will be aided by the inpatient rehabilitation care; and
- The intensity of service required cannot be provided in the outpatient setting; and
- The patient requires and will receive multidisciplinary team care, defined as at least two therapies (*i.e.* speech, occupational, physical, and/or respiratory therapies) provided on a daily basis (at least 3 hours per day, five days per week); and
- The patient's medical condition and treatment require physician supervision at least three times per week.

12. Alternative Medical

Benefits. The Fund now covers lymphedema and manipulative therapies. Effective April 1,

2002, the following language regarding alternative medical benefits replaces the current Fund language:

The Fund will consider up to \$60.00 per session for therapy rendered by a licensed physician as listed under Covered Providers below, up to a maximum of 50 sessions per year for any combination of services. The Fund will also cover one medical examination per month by the therapist or doctor to evaluate the patient's progress. Covered services are limited to:

- Acupuncture
- Biofeedback Therapy
- Chiropractic Care
- Lymphedema Therapy
- Manipulative Therapy
- Occupational Therapy
- Osteopathic Manipulative Therapy
- Physical Therapy

For purposes of this therapy benefit, the Fund will consider services consistent with the scope of practice and State license for the following service providers:

- Certified Acupuncturist
- Doctor of Chiropractic
- Doctor of Medicine
- Doctor of Oriental Medicine*
- Doctor of Osteopathy
- Registered Occupational Therapist

- Registered Physical Therapist

*The Fund provides coverage for a Doctor of Oriental Medicine only for the provision of acupuncture.

Note: The Fund **does not** provide coverage for practitioners including but not limited to masseurs, masseuses, dance therapists or other practitioners, health club/gym fees, Pilates or yoga, even when prescribed by a doctor.

13. Enhanced External Counterpulsation Therapy (EECP).

Effective April 1, 2002, coverage for EECP therapy will be limited to one 35 session program per year and only if provided by a Blue Cross Prudent Buyer, Private Healthcare Systems PPO, or Private Healthcare Systems POS network provider. Benefits for EECP services provided by a different provider may be covered at 75% of the network rate under certain circumstances.

14. Umbilical Cord Blood Testing. Effective April 1, 2002, the Fund will provide coverage for the testing and short-term storage of umbilical cord blood

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for a member who is undergoing treatment for which umbilical cord blood stem cells would be needed. Umbilical cord blood contains stem cells that may be used as an alternative to a conventional allogeneic bone marrow transplant for disorders such as leukemia, aplastic anemia and certain inherited metabolic disorders.

Note: The Fund will not cover charges to randomly freeze and/or store umbilical cord blood for possible future use.

15. Open Access Plan: Non-Network Anesthesiologists, Radiologists, and Emergency Room Doctors. These Open Access Plan benefits will be improved effective April 1, 2002. If you are enrolled in Open Access and receive services at a network facility, the benefit

reimbursement for non-network anesthesiologists, radiologists, and emergency room doctors will be paid at 85% of the reasonable and customary allowance. In the past, Participants enrolled in Open Access went to a network facility in order to increase their benefits, but sometimes incurred unexpected costs because the anesthesiologist, radiologist or emergency room doctor providing non-emergency services was not a network provider.

Note: If you go to a non-network facility, you will be subject to the non-network reimbursement rate and may not take advantage of this special rule.

If you have any questions about the information provided in this summary, please contact the Fund Office:

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