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and The Writers' Guild-Industry Health Fund

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KEEPING THE HEALTH FUND HEALTHY

Understanding New Dependent Premiums

How Rising Health Care Costs Are Affecting the Fund

Health care costs have been rising at an alarming rate for the past few years. The increases are having a tremendous impact on everyone from individuals to small businesses and multinational corporations. And they're having an impact on the Fund.

The Board of Trustees continues to take steps to help contain these costs in a variety of ways, but the steady health care inflation rate into the high teens makes it impossible to avoid asking the Health Fund's participants to share more of the expenses.

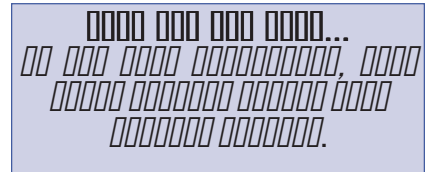
You've already received notice that the Board of Trustees voted to implement a premium for dependent coverage. Effective July 1, 2003, participants who cover their spouse, same sex domestic partner, children or other dependents will begin paying that monthly premium to the Health Fund.

Some of the other guilds, including SAG, DGA and IATSE, are making similar plan changes in order to support the goals of meeting the diverse needs of their populations and securing the financial stability of their organizations.

Since paying a premium for dependent coverage is a new procedure for Fund participants, this article provides some information to help you make a decision about covering your dependents.

What You'll Pay

If you want to cover your eligible dependents, you will pay a monthly premium of \$50 *in advance on a quarterly basis*. Your quarterly payment will be \$150 — that is \$50 per month for three months.



For **current eligible participants** with dependents, the Fund will issue quarterly invoices with return envelopes in advance of the due date. The invoice will show charges for all eligible quarters so that you can prepay your premium for more than one quarter if you wish. You can make premium payments by personal check or money order, by mail or in person, at the Administrative Office in Burbank. Cash or partial payments will not be accepted.

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The following table shows the dates your payments are due and for which time period:

Premium Due Date	For Eligibility Quarter
June 20	July 1 through September 30
September 19	October 1 through December 31
December 19	January 1 through March 31
March 19	April 1 through June 30

If you cover a same sex **domestic partner**, the *imputed income* (the cost of the premium for same sex domestic partner coverage, which the IRS requires the Fund to report as income to you) will be reduced to account for the \$150 quarterly payment, and taxes will be calculated accordingly.

Retroactive or Rescinded Coverage

Sometimes employer compliance audits uncover cases where a participant earned eligibility or lost eligibility due to earnings but was unaware of the correct status. The Fund then makes the appropriate adjustments:

- If you are *awarded retroactive eligibility* and want dependent coverage, you will have to pay monthly premiums retroactively for the number of (consecutive) quarters for which you want coverage.
- If your *coverage is rescinded*, the premiums you paid for the quarters involved will be refunded. If the Fund paid claims for you or your dependents during this time, you will be required to reimburse the Fund. In this case, the Fund will use the premium payments that were paid as a credit against the claims reimbursement due.

Termination of Dependent Coverage

If you do choose to cover your dependents and you fail to make a premium payment by the date it is due, **coverage for your dependents will be terminated**. The Fund will not allow reinstatement until the next Open Enrollment period, usually held in the fall for an effective date of January 1 of the following year—provided that you prepay the premium for that quarter.

Dependent Coverage Premium

WHO: Covers spouse or same sex domestic partner and all other eligible dependents whom you enroll for coverage

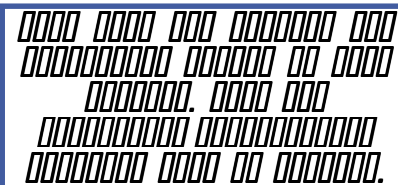
WHAT: \$50 per month, payable quarterly (\$150) in advance

WHEN: Premium due approximately 10 days prior to the end of the month before the eligibility quarter

Who Is Covered

The one \$50 monthly premium covers **all your eligible dependents**, including:

- Your spouse or same-sex domestic partner
- Children eligible for coverage as defined by the Plan.



If you cover a **dependent student** who is age 19 or older, student status verification is required.

KEEPING THE HEALTH FUND HEALTHY

How to Enroll Your Dependents

Within 30 days of the date your dependent becomes eligible for Health Fund benefits, you must submit a completed dependent card to the Fund. If you are not already paying a premium for dependent coverage, you will be asked to submit your quarterly payment with the dependent card.

If you don't enroll within the 30-day limit, you will not be able to enroll your dependent until the next Open Enrollment period.

Newly eligible participants will receive information in their eligibility kit about enrolling their dependents (within 30 days of their eligibility date) and paying the premium.

Changes in Status

Under certain circumstances, however, you will be able to add or drop dependent coverage during the year. If you experience one of the following **changes in status** you meet that requirement:

- Marriage, divorce or legal separation
- Birth or adoption of a dependent child or permanent placement of a child for foster care or adoption
- Death of a spouse or dependent

- Any change in spouse's or dependent's employment status that results in a significant change to benefits, such as the start or end of employment, change from full-time to part-time employment or start or end of an unpaid leave of absence
- Unmarried dependent's gain or loss of eligibility due to a change in age or student status
- Change in worksite or residence for the participant or his or her spouse or dependent, if that change affects benefits.

Other status changes may apply, such as a change in a family member's coverage. For example, if your spouse elects family coverage during his or her open enrollment period, this may allow you to drop your dependent coverage. Another instance occurs if the Fund is required to cover a dependent based on a legal judgment or court order. You may contact the Administrative Office if you have questions about these status changes.

You will not have to pay the entire \$150 quarterly premium

if your change in status takes place during the quarter. Your premiums will be prorated to the first day of the month in which the most recent change takes place. For example, if you get married on August 22 and you want to cover your spouse, you would report your marriage to the Fund and submit a dependent card. You would owe premiums for two months of the quarter: \$50 for August (an entire month's premium is required for changes during the month) and \$50 for September, for a total of \$100. If you submit \$100 to the Fund with your dependent card, your spouse will be covered as of August 22. If you do not make a premium payment at the time, you will not be able to enroll your spouse until the next Open Enrollment period and he or she will not be covered until January 1.

You must notify the Fund within 30 days of the **change in status** or your "add" or "drop" request will be delayed until the following Open Enrollment period for an effective date of January 1.

How This Change Will Affect You

You may or may not be affected by this change, based on your particular status:

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204(H) NOTICE RE PENSION PLAN AMENDMENTS

The Directors recently amended the Pension Plan to freeze its compensation and benefit limits. This change, which is effective July 1, 2003, will not reduce benefits that have already been earned and won't affect the vast majority of participants. This notice explains the impact of the change.

The Plan's retirement benefit formula is an annual benefit, payable at Normal Retirement Date, equal to 48.3% of the contributions on earnings subject to pension contributions made on your behalf, subject to certain limits on the amount of compensation that can be taken into account. Generally, employers are required to contribute 6% of your covered earnings. If, for example, your covered earnings in 2002 were \$170,000, your employer was obligated to contribute \$10,200, and you earned an annual benefit of \$4,926.60 (48.3% of \$10,200) payable at Normal Retirement Date.

The tax laws impose limits on the annual amount of compensation that can be taken into account. As shown on page 18 of your Summary Plan Description, the compensation limit was \$170,000/year for the years 2000 through 2002. In addition, there is also a second tax rule that imposes a limit on the maximum annual pension benefit payable at retirement; in 2002, the maximum benefit payable at age 65 in the form of a 5-year certain and life annuity was approximately \$138,000. The IRS did not increase these particular limits in 2003. These limits apply on an Employer (including affiliates) by Employer basis.

Before the amendment, both the compensation and benefit limits were adjusted for increases in the cost of living. These cost of living adjustments ("COLAs") were implemented in accordance with tax laws. The Directors recently completed an extensive review of the financial condition of the Pension Plan, which review took into account losses that have occurred over the last few years because of the general decline in the stock markets. Based on this review, the Directors have amended the Plan to eliminate future COLAs. As a result, the compensation limit will remain at \$170,000/year and the maximum annual benefit of approximately \$138,000 will not change.

How will this affect your benefit? First, it will not change benefits you have already earned. They are protected.

Second, most participants aren't affected at all. The change only impacts participants whose covered earnings would have exceeded \$170,000 per employer in a future year. (There may also be a handful of participants who are impacted by the benefits limit.) Even here, the impact on your future benefit may vary widely since it depends on the number of years in which you will have earnings over \$170,000 and what the future COLAs would have been. Since 1989, when the compensation limit was adopted, the annual adjustment factors have ranged from 1.12% to 5.95% per year. In the last decade the annual adjustment factors have ranged from 1.60% to 3.51% per year.

Some examples may help explain the impact of the change. As already noted, if you never earn more than \$170,000 per employer in a future year, the changes will have no impact on your benefit – you will earn the same benefit under the new rules that you earned before.

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On the other hand, consider a participant who consistently earns well above \$170,000 per employer per year every year. Assume the first year of coverage under the Pension Plan is 2003. Under the new rules, each year, the participant will earn an annual benefit payable at age 65 of \$4,926.60 for each year worked. If the participant works 25 years (that is, from 2003 through 2027), the benefit at age 65 would be \$123,165.

If instead there were a **1.6%** COLA each year starting in 2004 and the plan had applied a COLA adjustment, the total benefit earned over the 25-year period would have been \$146,059.20, a difference of 18.6%. By way of contrast, assume the participant would have worked only 10 years (from 2003 through 2012) in total. In this case the benefits earned after the amendment would be \$49,266, as contrasted to \$51,584.40 before the amendment if the Pension Plan had applied a COLA adjustment, a difference of 4.7%. The computations in this and the next paragraph take into account a special tax rule that says that COLA adjustments can only be made in increments of \$10,000.

Now assume that the COLA increase was **3.5%** every year. In this case the participant's benefit over this 25-year period would be \$123,165 after the amendment, as opposed to \$188,080.20 before the amendment if the Pension Plan applied a COLA adjustment, a difference of 52.7%. If the participant only worked a total of 10 years, the participant would earn \$49,266, as opposed to \$56,511 before the amendment if the Pension Plan applied a COLA adjustment, a difference of 14.7%.

Your particular situation will depend, of course, on your individual earnings and what the future COLAs would have been.

If you have any questions, please contact the Pension Benefits Department at the Administrative Office.

DEAR DOROTHY

Dear Dorothy:

My calendar is booking up fast! When is the annual Health Fair and Pension Open House scheduled this year?

-Planner in Port Leyden

Dear Planner:

The Health Fair and Pension Open House has not been scheduled yet, but it will be sometime this fall. Announcements will be sent when the exact date is known. We hope you will still be available to join us!

Dear Dorothy:

I received my Annual Pension Plan Statement for 2002 about a month ago. I worked back in the early 1980's and then left the Industry for a while before I came back. Why are the contribution amounts for my years in the early 1980's showing as zero?

-Lost in Lyons Falls

Dear Lost:

Well, you will recall that prior to 1998, there were Break in

Service rules. It sounds like you incurred a permanent Break in Service when you left the Industry, which resulting in the loss of all your accumulated Qualified Years and contributions. Since those previous years are lost for retirement benefits, they appear as zero on your Statement. The permanent Break in Service should also appear on your Statement. Luckily, the Break in Service rules are not like that anymore, and you will not forfeit

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NEW CLAIM PROCEDURES

The following claim procedures are effective for claims filed on or after January 1, 2003 under the Writers' Guild-Industry Health Fund (the "Health Fund").

A claim is a request for a Health Fund benefit by a participant or beneficiary (or a provider if benefits have been assigned to the provider). The Health Fund's new claim procedures for all Health Fund claims are described below. The claims procedures for the HMO benefit option are set forth in the HMO evidence of coverage. Thus, the rest of these procedures do not apply to HMO participants' claims for benefits.

Filing Claims in General

How claims are processed depends on the type of claim. Who processes the claim also depends on the type of claim. Certain claims, such as dental benefits, and UBH mental health benefits must be submitted to the applicable third party claim administrator. All other claims must be submitted to the Administrative Office. Generally, if you receive services from a network provider, the provider will submit the claim to the Health Fund directly. If you receive services from a non-network provider, either you or your provider will submit the claim to the Health

Fund. Each third party administrator as well as the Administrative Office are referred to herein as a "Claim Administrator." Refer to your Summary Plan Description for contact information for these different Claim Administrators. You may refer to your Summary Plan Description for contact information for the applicable Claim Administrators.

You may designate an authorized representative for assistance with respect to your claim for benefits. If you wish to do so, please contact the Claim Administrator for more information.

Initial Claim Determinations

The Claim Administrator has full discretion to deny or grant a claim in whole or part. Such decisions shall be made in accordance with the governing Health Fund documents and, where appropriate, Health Fund provisions will be applied consistently with respect to similarly situated claimants in similar circumstances. The Claim Administrator shall have the discretion to determine which claimants are similarly situated in similar circumstances.

How and when claims are processed depends on what type of claim it is. All claims under the Health Fund that are required to be submitted to the Administrative

Office are post-service health care claims. Most other claims under the Health Fund will also be post-service health care claims. The rules for pre-service claims are at the end of this article.

Post-Service Health Care Claims

- A post-service claim is a claim for benefits after services or treatment have been provided.
- The Claim Administrator will notify the claimant of a denial within a reasonable period of time but not later than 30 days after receipt of the claim, unless an extension of 15 days is necessary due to circumstances beyond the Health Fund's control. If the reason for the extension is because the Claim Administrator does not have enough information to decide the claim, the notice will describe the required information and the claimant will have 45 days from the date the notice is received to provide the necessary information.

Contents of Denial Notices

Any notice of an adverse benefit decision shall include the following:

- The specific reason or reasons for the adverse determination;
- Reference to the Health Fund provisions on which the determination is based;

NEW CLAIM PROCEDURES

- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why the information is necessary;
- A description of the Health Fund's review procedures, the time limits applicable to such procedures, and the claimant's right, at no charge, to have reasonable access to and to obtain copies of all relevant documents upon request therefore, and a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse determination on review;
- If an internal rule or guideline was applied in making the determination, a statement that the rule will be provided free of charge upon request;
- If the determination is based on a medical necessity or experimental exclusion, a statement that an explanation of the scientific or clinical judgment applied to make the determination will be provided free of charge upon request; and
- If the determination affects a claim for urgent health care, a description of the expedited review process applicable to such claims.

Appealing a Claim Denial

If a claim is denied, the claimant will have 180 days from receipt of the denial to submit a written appeal of the determination. The appeals decision for any claims denied by the Administrative Office will be conducted by the Benefits Committee (the "Committee") of the Board of Trustees of the Health Fund. Appeals of claims determined by a Claim Administrator other than the Administrative Office will be reviewed by such third party Claim Administrator.

The claimant may submit written comments and other information relating to the claim for consideration on appeal. The claimant will be provided, upon request and free of charge, other information relevant to the claimant's claim, including the identity of any medical consultant who reviewed the initial claim. The appeals decision will not afford deference to the initial adverse determination and will be conducted by an individual or individuals who are neither the individual who made the initial determination nor his subordinate.

Decisions on Appeal

The Claim Administrator's review will take into account all comments, documents, records and other information submitted

regardless of whether the information was previously considered on initial review. The Claim Administrator will have discretion to deny or grant the appeal in whole or part. Such decisions shall be made in accordance with the governing Health Fund documents and, where appropriate, Health Fund provisions will be applied consistently with respect to similarly situated claimants in similar circumstances. The Claim Administrator shall have discretion to determine which claimants are similarly situated in similar circumstances.

Reviews of denials by the Administrative Office will be heard by the Committee at its next regularly scheduled quarterly meeting. However, if an appeal is received within 30 days before the meeting, the review will be delayed until the next meeting. In addition, if special circumstances require further extension of time, the review may be delayed to the following meeting. Once the benefit determination is made, the claimant will be notified as soon as possible, but not later than 5 days after the determination.

For appeals of claims denied by a party other than the Administrative Office, the claimant will be notified of the determination within a reasonable period of

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NEW CLAIM PROCEDURES

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time, but not later than 60 days after receipt of the request for review.

If the decision to deny the claim was based in whole or in part on a medical judgment, the Claim Administrator will consult with a health care professional who has experience and training in the relevant field and who was not involved in the initial determination. Identification of any such health care professional will be provided to the claimant upon request and free of charge.

Contents of Notice of Decision on Appeal

Any notice of an adverse determination shall include the following:

- The specific reason or reasons for the adverse determination;
- Reference to the Health Fund provisions on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to the claimant's claim;
- A statement describing the claimant's right to bring an action under ERISA Section 502(a);
- If the determination is based on a medical necessity or

experimental exclusion, a statement that an explanation of the scientific or clinical judgment applied to make the determination will be provided free of charge upon request; and

- If an internal rule or guideline was applied in making the determination, a statement that the rule will be provided free of charge upon request.

No lawsuit may be brought with respect to Health Fund benefits until the foregoing administrative procedures have been exhausted. Additionally, no lawsuit may be brought more than two years following the date the Health Fund notifies the claimant of a final adverse determination under the Health Fund.

Pre-Service Health Care Claims

While most claims for benefits under the Health Fund are post-service claims subject to the rules described above, some claims require pre-approval and are considered pre-service claims. A claim is only a pre-service claim if failure to obtain approval prior to service results in a reduction or denial of benefits that would otherwise be covered. Claims requiring pre-approval include certain dental claims (these are submitted to Delta Dental) and UBH mental health benefits (these

are submitted to UBH).

There are three types of pre-service health care claims: urgent care claims, non-urgent care claims, and concurrent care claims. The rules described above apply to pre-service claims, except as described below:

- If a health care claim is a pre-service claim but is not a claim for urgent health care, the Claim Administrator will notify the claimant of a denial within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receiving the claim, unless an extension of 15 days is necessary due to circumstances beyond the Health Fund's control. If the reason for the extension is because the Claim Administrator does not have enough information to decide the claim, the notice will describe the required information and the claimant will have 45 days from the date the notice is received to provide the necessary information.
- If the health care claim is a pre-service claim for urgent health care, the Claim Administrator will notify the claimant of the determination as soon as possible, but not later than 72 hours after receipt of the claim. If the claimant fails to provide sufficient

NEW CLAIM PROCEDURES

information for determination, the claimant will be notified of the missing information as soon as possible but not later than 24 hours after receipt of the claim. The claimant will have a reasonable period of time (at least 48 hours) to provide the missing information. The claimant will then receive an eligibility determination no later than 48 hours after the earlier of (1) the Health Fund's receipt of the missing information or (2) the end of the period provided for the claimant to submit the missing information, provided the Claim Administrator will not be required to provide a determination before the original 72-hour period expires.

- Special rules apply for concurrent care decisions, which are decisions involving an approved ongoing course of treatment, either for a specific period of time or for a specific number of treatments. A reduction or termination of the course of treatment before the approved time period or number of treatments will be considered a claim denial. If this occurs, the participant will be notified sufficiently in advance in order to appeal the decision before the benefit is reduced or terminated. For example, if UBH approves a three week period of inpatient

mental health coverage and then determines mid-treatment that three weeks is inappropriate, the decision to shorten the three-week period is subject to the concurrent care rules.

On the other hand, claimants may request an extension of the course of treatment beyond the approved time period or number of treatments. For example, if UBH approves a three-week period of inpatient mental health coverage and the claimant wants to extend the coverage beyond three weeks, this is also a concurrent care claim. If such a concurrent care claim involves urgent care, the Claim Administrator will provide notice of the determination within 24 hours of receiving the request, as long as the request is made at least 24 hours before the approved time period or number of treatments expires. If the request does not involve urgent care, the normal pre-service health care claim rules apply.

- If a claimant fails to follow the Health Fund's claim procedures for filing a pre-service claim, the claimant will be notified of the failure and the proper procedures to follow in filing a claim for benefits. The notice will be provided not later than 5 days (or 24 hours for an urgent care

claim) after receipt of the claim. This provision applies only if the claim was received by a person customarily responsible for handling Health Fund benefit matters and includes the name of the claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

- If a pre-service claim for urgent health care is denied on appeal, the claimant will be notified of the eligibility determination as soon as possible, but not later than 72 hours after receipt of the request for review.
- If a pre-service claim for health benefits that does not involve urgent health care is denied on appeal, the claimant will be notified of the determination within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review.

Please call the Fund at 818-846-1015 should you have any questions about these procedures.

KEEPING THE HEALTH FUND HEALTHY

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If you do not have dependents or do not wish to cover your dependents under the Health Fund, premium payments do not apply to you. Your individual coverage does not require a premium payment.

- If you are a Certified Retiree who is Medicare-eligible, you are not required to pay dependent coverage premiums.
- If you are making COBRA payments, COBRA rates will not change as a result of this premium.

These changes are being made today in consideration of your future benefits. The Board of Trustees is committed to continuing to provide valuable health care options for eligible participants and their families. The way to do that is to maintain a healthy, stable Fund capable of offering quality benefits in the months and years ahead.

Qualified Years or contributions if you leave the Industry and come back.

Dear Dorothy:

I visit the Administrative Office regularly, and I used to just walk to the area where I needed to speak with someone. Now, I can't do that, and I was told that I needed to be escorted! Why?

-Escorted in Elmira

Dear Escorted:

That's right, any visitors to the Administrative Office need to be escorted. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") protects each Participant's protected health information. To help maintain the protection of this information under HIPAA, visitors to the Office are supervised within the Office. Thus, any visitor has to be escorted through the Office. Please keep that in mind when

you visit and check in with the Security Desk on the first floor and go to the Receptionist on the second floor to obtain your escort. Thanks for your cooperation!

HAVING TROUBLE GETTING YOUR PRESCRIPTIONS LATELY?

If recently you tried to refill an existing prescription or fill a new prescription at your regular pharmacy, your pharmacist may have received a denial from AdvancePCS. The reason is the change-over to your new ID numbers. In April you received your new all-in-one ID card, which contains a new group number for AdvancePCS. Because your pharmacist's computer system contains your previous group number, your claim was denied. In order to resume your coverage, just present your new card to your pharmacist. Once your new number is in the system, your claims will be properly processed. If you have not received your new ID card(s), please call the Eligibility Department at the Administrative Offices.

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