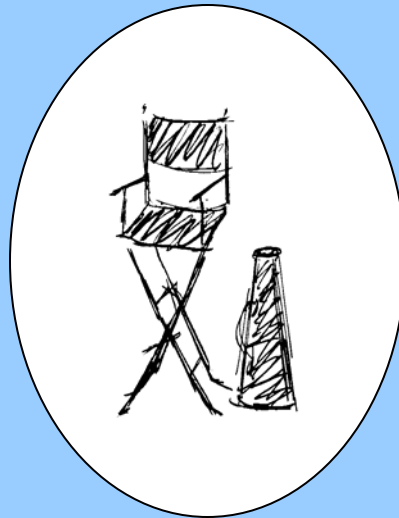


Directors Guild of America – Producer Health Plan



Health Plan Booklet

Revised July 1, 2003

The Board of Trustees is pleased to provide you with this Summary Plan Description and Plan Document for the benefits currently offered by the Directors Guild of America – Producer Health Plan (the “*Health Plan*”). We have prepared this booklet as of July 1, 2003, to serve as a guide and reference concerning all aspects of your health care benefits and how to use them.

Periodically, changes are made to the *Health Plan*. As a participant, you are notified through the *Health Plan*'s newsletters or other special mailings. For easy reference, we recommend that you keep your *Health Plan* correspondence in the pocket inside the back cover of this booklet.

We've tried to explain the *Health Plan* in plain, straightforward language, but you may come across some terms not used in everyday conversation. That's because it is necessary to use certain specialized terms in order to be specific about your benefits. At other times, common terms have special meaning in this *Health Plan*. In this booklet, terms that are defined in the Glossary are in italics. To better your understanding of this booklet, we suggest that you first familiarize yourself with the terms in the Glossary.

When benefits are provided by insurance contracts or health maintenance organizations (HMOs), the legal and policy terms of any group master contracts issued to the Directors Guild of America – Producer Health Plan will prevail in interpretation of questions relative to subject matter in this booklet. The nature and extent of benefits provided by the Directors Guild of America – Producer Health Plan and the rules governing eligibility are determined solely and exclusively by the Board of Trustees. Employees of the Health Plan Office have no authority to alter those benefits and eligibility rules. Any interpretations or opinions given by employees of the Health Plan Office are not binding upon the Trustees and cannot enlarge or change such benefits and eligibility rules. The Trustees are charged with the responsibility of interpreting the provisions of the *Health Plan* and establishing rules and regulations to assist in the administration of the *Health Plan*. They also determine the *Health Plan*'s schedule of benefits and will rule on appeals of participants with respect to benefit denials. In addition, the benefits described in this booklet, while intended to remain in effect indefinitely, may be amended or terminated by the Trustees at any time. These benefits and eligibility to receive these benefits are not guaranteed and may be changed at any time.

If you have any questions, please call the Health Plan Office.

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Schedule of Benefits

FOR PARTICIPANTS AND DEPENDENTS

COMPREHENSIVE MAJOR MEDICAL

Calendar Year Deductible	\$300 per person; \$900 per family; no deductible for inpatient psychiatric and substance abuse programs
Dependent Premium (effective 10/1/03)	\$600 annually, per family (no premium for participant-only coverage)
Percentage Payable General Charges (hospital, surgery, office visits, lab, x-ray, etc.)	<i>PPO</i> 90% of <i>covered expenses</i> <u>Non-PPO – DGA Premier Choice Plan</u> 70% of <i>covered expenses</i> <u>Non-PPO – DGA Choice Plan</u> 60% of <i>covered expenses</i>
Inpatient Psychiatric Care and Substance Abuse	Requires pre-authorization from Entertainment Industry Referral & Assistance Center (EIRAC) or The Actors' Fund of America; 90% of <i>covered expenses</i> for the 1st hospitalization; 80% of <i>covered expenses</i> for the 2nd hospitalization; 70% of <i>covered expenses</i> for the 3rd hospitalization; 50% of <i>covered expenses</i> for the 4th hospitalization; 50% of <i>covered expenses</i> for the 5th and later hospitalizations
Outpatient Psychiatric	Payable at 50% of <i>covered expenses</i>
Calendar Year Out-of-Pocket Limit (Certain charges do not apply)	<i>PPO</i> \$1,000 per person; in excess of deductible <u>Non-PPO – DGA Premier Choice Plan</u> \$3,000 per person; in excess of deductible <u>Non-PPO – DGA Choice Plan</u> \$7,500 per person; in excess of deductible
Maximum Lifetime Benefit	\$2,000,000; with up to \$5,000 annual automatic restoration

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Schedule of Benefits

Limitations

Physical Therapy *Covered expenses may not exceed \$85 per visit; maximum of 50 visits per calendar year*

Acupuncture and Chiropractic Care *Covered expenses for acupuncture may not exceed \$85 per visit; Covered expenses for chiropractic care may not exceed \$50 per visit; maximum of 20 visits each per calendar year*

Psychiatric Care – Inpatient *Requires preauthorization from EIRAC or The Actors' Fund*

Psychiatric Care – Outpatient *Maximum of 20 visits per calendar year*

Substance Abuse Programs *Requires preauthorization from EIRAC or The Actors' Fund; lifetime maximum payment of \$30,000*

Private Duty Nursing *Maximum payment of \$25,000 per calendar year*

PRESCRIPTION DRUGS (Express Scripts)

Retail – up to 30-day supply
Generic
\$10 co-payment
Brand Name
\$24 co-payment
Specialty
Covered at 50% with \$40 minimum co-payment

Mail Order –
up to 90-day supply
Generic
\$25 co-payment
Brand Name
\$60 co-payment
Specialty
Covered at 50% with \$60 minimum co-payment

WELLNESS BENEFIT

A \$1,500 per family per calendar year allowance for wellness and/or preventive care.

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Schedule of Benefits

DENTAL BENEFITS

Using a DPO or "in-network" dentist:

Calendar Year Deductible	None
Percentage Payable	<u>Category I Charges</u> 100% of covered expenses <u>Category II Charges</u> 80% of covered expenses <u>Category III Charges</u> 70% of covered expenses

Using a non-DPO or "out-of-network" dentist:

Calendar Year Deductible	\$50 per person; \$100 per family; no deductible for orthodontia
Percentage Payable	<u>Category I Charges</u> 85% of covered expenses <u>Category II Charges</u> 60% of covered expenses <u>Category III Charges</u> 50% of covered expenses

Orthodontia

(coverage only available for dependent children age 19 and younger)

50% of covered expenses; lifetime maximum payment of \$1,500 per dependent child; no deductible

Calendar Year Maximum \$2,500 per person

VISION CARE BENEFITS — For services received from VSP providers.

Co-Payment

Exams	\$30
Lenses and Frames	\$30

Service Frequency

Exams	Once every calendar year
Lenses	Once every calendar year
Frames	Once every other calendar year

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Directory of Plan Benefit Providers

Directors Guild of America – Producer Health Plan
8436 West Third Street, Suite 900
Los Angeles, California 90048-4189

(323) 866-2200 – Main Number
(877) 866-2200 – Toll-Free Outside of the Los Angeles Area
(323) 782-9287 – Health and Eligibility Department Fax Number

Actors' Fund of America, The (800) 221-7303 or (212) 221-7301

Blue Cross of California (800) 888-4825
www.bluecrossca.com

Delta Dental of California
Benefits, eligibility and claims (800) 846-7418
To find a Delta Dental *DPO* dentist (800) 4-AREA-DR
www.deltadentalca.org

Entertainment Industry Referral and Assistance Center (**EIRAC**) (818) 981-6789

Express Scripts (800) 789-6443
(Customer Service and www.express-scripts.com
Mail Order Prescriptions)

Industry Advantage, The (**TIA**) (800) 721-7217

Industry Health Network, The (**TIHN**) (800) 876-8320
www.mptvfund.org

Private Healthcare Systems, Inc. (**PHCS**)
California residents traveling outside California (800) 355-7962
Non-California residents (888) 847-7427
www.phcs.com

Vision Service Plan (**VSP**) (800) 877-7195
www.vsp.com

Periodically, the *Health Plan* may add, drop or replace plan benefit providers.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Eligibility

- Earned coverage
- Self-pay coverage
- Termination of eligibility
- Eligible dependents
- Coverage extensions
- Conversion of coverage

Eligibility

This section details *Health Plan* eligibility and participation. This section also details who may qualify as eligible dependents. No portion of this *Health Plan* is guaranteed. The Trustees reserve the right to change, cancel or terminate the *Health Plan*, or any aspect of the *Health Plan*, at any time.

The *Health Plan* provides a comprehensive package of health care and survivor benefits for eligible participants and their eligible dependents. In general, you are eligible for *Health Plan* coverage if you:

- have sufficient *covered earnings* (from current employment or residuals);
- have sufficient carry-over credits;
- are a Certified Retiree and pay the required premiums;
- are retired with retiree carry-over credits and pay the required premiums; or
- are eligible to self-pay for *Health Plan* benefits and pay the required premiums.

■ EARNED COVERAGE

CONTRIBUTIONS

The *Health Plan* is supported by employer contributions. The contribution rates are negotiated pursuant to collective bargaining agreements by the Directors Guild of America, Inc. and Producers or Producer representatives in the motion picture, television and commercial production industries. Currently, contributions are made to the *Health Plan* by an employer signatory to a collective bargaining agreement between the above-referenced parties at an amount equal to 7% of your *covered earnings* for work performed in a DGA capacity.

Earned coverage under the *Health Plan* can only be acquired through employer contributions. Employer contributions reported in any way other than the way described in the applicable collective bargaining agreement are unacceptable and could affect your eligibility and benefits in the past, present and future. Your coverage is based on contributions received, not the level of *covered earnings*. However, earnings equivalents are sometimes used in this booklet for your convenience. Earnings and contributions are generally recognized by the *Health Plan* based on when the work was performed, regardless of when the contributions were received by the *Health Plan*. Contributions based on residuals are recognized by the *Health Plan* based on the air date, or for prepaid residuals, the work period.

INITIAL ELIGIBILITY

If you meet one of the following descriptions, you will become eligible for *earned coverage* during a benefit period:

- you perform services covered under a DGA–Producer collective bargaining agreement and you generate contributions on at least the minimum acceptable earnings during an earning period; or
- you are a regular full-time employee of the Directors Guild of America, Inc. or the Health Plan Office. If you are such an employee, please refer to the supplement for non-collectively bargained employees for eligibility and enrollment information.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

If you qualify for *earned coverage*, your eligible dependents may also receive *Health Plan* benefits. Effective October 1, 2003, a premium is required for dependent coverage. Please see page 24 for more information on the dependent premium.

EARNING PERIOD

To qualify for *earned coverage*, you must generate minimum earnings or residuals during one of the 12-month earning periods. Earning periods begin on January 1, April 1, July 1 and October 1. Your earning period starts with the first quarter in which you generate earnings. *Covered earnings* generated during an earning period can only be applied towards the corresponding benefit period that begins after the current earning period. Any *covered earnings* used to qualify for health coverage, in part or in full, cannot be used again.

The minimum earnings requirement may be periodically adjusted by the Board of Trustees.

BENEFIT PERIOD

A benefit period is the 12-month period during which you are eligible for coverage under the *Health Plan*. Benefit periods begin January 1, April 1, July 1 and October 1.

Due to the time needed to receive and process contributions on your behalf, there is a mandatory three-month (one calendar quarter) waiting period between the end of the earning period in which you qualify for *earned coverage* and the beginning of your corresponding benefit period. For example, if you qualify for *earned coverage* during the April 1, 2003 to March 31, 2004 earning period, your health coverage will be in effect during the July 1, 2004 to June 30, 2005 benefit period.

Once your coverage begins, it remains in effect for a full year, or one benefit period. Participants cannot qualify for more than one benefit period at a time. A benefit period must be used in full (12 months) before a new benefit period can begin. The following chart shows when coverage begins based on when the minimum earnings are generated:

IF YOUR 12-MONTH EARNING PERIOD IS	MINIMUM EARNINGS REQUIRED IS	YOUR 12-MONTH BENEFIT PERIOD IS
10/1/2002 – 9/30/2003	\$28,700	1/1/2004 – 12/31/2004
1/1/2003 – 12/31/2003	\$28,700	4/1/2004 – 3/31/2005
4/1/2003 – 3/31/2004	\$28,700	7/1/2004 – 6/30/2005
7/1/2003 – 6/30/2004	\$28,700	10/1/2004 – 9/30/2005

A participant who meets the minimum earnings required for automatic health coverage based on earnings from current work with a signatory employer is given active *earned coverage*. A participant who has active *earned coverage* is considered an active participant.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Eligibility

A participant who meets the minimum earnings required for automatic health coverage after taking into account income from residuals is given inactive *earned coverage*. A participant who has inactive *earned coverage* is considered an inactive participant.

This distinction between active *earned coverage* and inactive *earned coverage* has no bearing on the benefits you receive from the *Health Plan*, but it may affect coordination of benefits with *Medicare* or any other insurance carrier you or your dependents have. For additional information, please refer to page 42.

DGA CHOICE AND DGA PREMIER CHOICE

There are two levels of benefits under the *Health Plan*: the DGA Choice Plan and the DGA Premier Choice Plan. A participant generating health contributions on earnings between the minimum for *earned coverage* and \$90,000 will be covered under the DGA Choice Plan. A participant generating health contributions on earnings of \$90,000 or more will be covered under the DGA Premier Choice Plan. The differences in the levels of benefits between the DGA Choice Plan and the DGA Premier Choice Plan are detailed in the sections of this booklet that describe the benefits offered by the *Health Plan*. In addition, further details are located on page 32.

Once you generate sufficient earnings to qualify for *earned coverage* during an earning period, the coverage you receive for that earning period will last for 12 months. Any earnings generated after that earning period will be applied to your next 12-month earning period. For example, say you initially generate \$40,000 in earnings in June 2004. Your earning period will be July 1, 2003 to June 30, 2004. You would then qualify for *earned coverage* in the DGA Choice Plan during the October 1, 2004 to September 30, 2005 benefit period. If you subsequently generate another \$100,000 in earnings in July 2004, those earnings would apply to the July 1, 2004 to June 30, 2005 earning period. As a result, you would be covered under the DGA Premier Choice Plan during the October 1, 2005 to September 30, 2006 benefit period. If you then generated \$50,000 in earnings during the July 1, 2005 to June 30, 2006 earning period, you would qualify for coverage during the October 1, 2006 to September 30, 2007 benefit period under the DGA Choice Plan. See the example below:

COMPENSATION REPORTED	12-MONTH EARNING PERIOD	CORRESPONDING 12-MONTH BENEFIT PERIOD	COVERED UNDER
\$40,000	7/1/03-6/30/04	10/1/04-9/30/05	DGA Choice Plan
\$100,000	7/1/04-6/30/05	10/1/05-9/30/06	DGA Premier Choice Plan
\$50,000	7/1/05-6/30/06	10/1/06-9/30/07	DGA Choice Plan

*These examples are based on eligibility rules as of July 1, 2003. The amount necessary to qualify for *earned coverage* in both the DGA Choice Plan and the DGA Premier Choice Plan is subject to change.

If there is an adjustment that reduces the amount of your acceptable contributions (as a result of an audit or otherwise), you will be held responsible for any benefits that were paid on your behalf

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

that would not have been paid had the contributions been properly reported. This can include both the loss of coverage or coverage that switches from the DGA Premier Choice Plan to the DGA Choice Plan.

If there is an adjustment that increases the amount of your acceptable contributions (as a result of an audit or late contributions received), you will be eligible to receive benefits that you would have been eligible for had the contributions been properly reported in a timely manner. Please note that you will be eligible for those benefits based on the earning period during which the *covered earnings* were earned, not when the adjustment was made. For example, if contributions are underreported on your behalf for *covered earnings* earned in July 2000, and the underreporting of contributions is discovered in July 2002, the underreported contributions will still be credited to July 2000, not July 2002. If the additional contributions result in health coverage that was not previously earned, or in a switch from coverage in the DGA Choice Plan to the DGA Premier Choice Plan, you are eligible to submit any additional health claims to the *Health Plan* that were not previously submitted during the corresponding benefit period. There is a three-year limit on submitting such claims that may be extended in case of an audit. In addition, the claims previously submitted on your behalf for that benefit period will automatically be re-adjudicated by the *Health Plan*, taking into account the new level of coverage, if any.

Make sure that contributions are properly reported on your behalf. You will be held responsible for overpaid benefits if contributions are overreported on your behalf. If contributions are underreported on your behalf, you may not receive all of the benefits for which you should have been eligible.

ASSISTANT DIRECTOR TRAINEES

Assistant Director Trainees qualify for coverage based on the rules of the Training Plan. Coverage for Trainees is provided through a health maintenance organization (HMO). If you are a Trainee, please contact the Training Plan Office for details.

MAINTAINING YOUR EARNED ELIGIBILITY

Once you establish your initial eligibility for benefits, you can maintain your *earned coverage* in one of two ways:

- continue to meet the minimum *covered earnings* requirement; or
- use your carry-over credit.

CARRY-OVER CREDIT

With sufficient contributions, you can accumulate carry-over credit. Carry-over credit allows you to “bank” eligibility in a year that contributions from *covered earnings* are in excess of a certain threshold. The excess contributions are banked for the purpose of being used in a future earning period in which your earnings are below the minimum earnings requirement to qualify for *earned coverage*. Under the rules that became effective January 1, 2003, for earning periods ended September 30, 2002 and later:

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Eligibility

1. the threshold after which earnings will be banked is \$120,000 (\$8,400 in contributions);
2. the maximum amount of *covered earnings* that can be banked in any one year is \$120,000 (\$8,400 in contributions); and
3. the maximum balance of *covered earnings* permitted in an individual's carry-over credit account is \$360,000 (\$25,200 in contributions).

If you do not meet the minimum earnings requirement for *earned coverage* during an earning period and you have banked sufficient carry-over credit in your account, the *Health Plan* will automatically deduct \$8,400 in contributions from your carry-over credit account for one year of *Health Plan* coverage, an additional \$8,400 in contributions for the second year of coverage, if needed, etc. Please note that the full \$8,400 will be deducted regardless of how close you are to meeting the minimum earnings requirement. Because \$25,200 in contributions is the maximum carry-over credit account balance, there is a maximum of three years of carry-over credit that can be banked at any given time. There is no expiration date on the amounts banked to your carry-over credit account.

Please note that the amount of carry-over credit required for one year of *Health Plan* coverage may increase in the future. The amount banked in your carry-over credit account is based on the amount of carry-over credit that is needed for one year of health coverage at the time the carry-over credit is banked. However, the amount needed for one year of health coverage at the time the carry-over credit is used may be more than the amount banked when the carry-over credit was earned. For example, let's say \$8,400 in contributions is banked into your carry-over account in 2004. Five years later, in 2009, you do not have sufficient earnings for *earned coverage*. However, as the result of a rule change, \$9,100 in carry-over credit is needed for one year of health coverage in 2009. You would need to have banked an additional \$700 in contributions in your carry-over credit account to qualify for *Health Plan* coverage based on carry-over credit.

Any years of eligibility earned through carry-over credit will be credited as *earned coverage* years and count towards Certified Retiree status and self-pay credits in the same manner as *earned coverage*. Whenever carry-over credit is used for *Health Plan* coverage, the coverage is considered to be inactive *earned coverage* for coordination of benefits purposes (see page 42).

Participants qualifying for health coverage through carry-over credit will be covered under the DGA Choice Plan, see page 32.

Carry-over credit cannot be combined with self-pay premiums or employer health contributions.

If you do not have enough carry-over credit to meet the contribution requirement for *earned coverage*, you may be eligible to continue your benefits on a self-pay basis.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

SELF-PAY COVERAGE

COBRA CONTINUATION COVERAGE

A federal law known as the Consolidated Omnibus Budget Reconciliation Act (*COBRA*) provides for continuation of *Health Plan* coverage for you and your eligible dependents on a self-pay basis if you or your eligible dependents lose coverage based on certain qualifying events.

Under *COBRA*, you are eligible to self-pay for health coverage for you and/or your eligible dependents for a period of time that is determined by certain qualifying events. The qualifying events are shown in the chart below, along with the duration of continuation coverage available as a result of each qualifying event.

QUALIFYING EVENT	COBRA COVERAGE MAY CONTINUE FOR	MAXIMUM DURATION OF COBRA COVERAGE
your earned coverage terminates	you and your eligible dependents	18 months (29 months for the disabled person if you or one of your eligible dependents are disabled at the time of the qualifying event or become disabled within 60 days of the qualifying event*)
you die	your dependents	36 months
you are divorced from your spouse	your dependents	36 months
your dependent children cease to qualify as eligible dependents	your dependent children	36 months

*An award of disability benefits from the Social Security Administration is required to receive the additional 11 months of coverage.

COBRA CONTINUATION PERIOD

The maximum duration of *COBRA* continuation coverage for the death of a participant, divorce, or loss of dependent status is 36 months. The maximum duration of *COBRA* continuation coverage for a termination of employment (other than for gross misconduct) is 18 months. However, this 18-month period may be extended for affected individuals to 36 months from the loss of coverage (the “termination date”) if other events such as the death of the participant, divorce, or child’s loss of dependent status occur during the 18-month period. To receive this extension, the participant or a family member must notify the Health Plan Office within 60 days of a divorce or dependent child’s loss of eligibility.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Eligibility

If the participant became entitled to *Medicare* before his or her termination, the participant's spouse and dependent children, if any, may elect continuation coverage for up to the greater of: (1) 18 months from the termination date; or (2) 36 months from the date of the participant's *Medicare* entitlement. If the participant becomes entitled to *Medicare* after his or her termination, the participant's spouse and dependent children, if any, may elect to continue coverage for an additional 18 months, for a total of 36 months from the termination date.

In no event will *COBRA* continuation coverage last beyond 36 months from the termination date. The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of *COBRA* continuation coverage. This 11-month extension is available to all disabled individuals who are qualified beneficiaries due to the same original qualifying event. This extension is only available if the Health Plan Office is notified of the disability within 60 days of the Social Security Administration's determination and within the initial 18-month period. Notwithstanding the foregoing, the 11-month extension will terminate early if the Social Security Administration determines that the disabled individual is no longer disabled. Federal law requires that you inform the Health Plan Office of any final determination that the disabled individual is no longer disabled within 30 days of such determination.

When the Health Plan Office notifies you of your right to elect *COBRA* continuation coverage, you will have 60 days from the later of the date you receive the notice or the date you would otherwise lose coverage because of a qualifying event to elect to continue coverage. If you do not make such an election within that time frame, your coverage will terminate.

Your *COBRA* continuation coverage period will terminate early under either of the following circumstances:

1. You do not pay your premiums on time. (See the "Premium Payments" section on page 17 for a description of when premiums are due.)
2. The *Health Plan* no longer provides group health care coverage.

If the Health Plan Office is not notified within 60 days of your qualifying event, you will forfeit your right to enroll in any of the *Health Plan's* continuation coverage programs and will be responsible for reimbursing the *Health Plan* for any benefits paid on your behalf or on behalf of your dependents. You must also notify the Health Plan Office within 60 days if you are adding or deleting a dependent.

SPOUSE AND DEPENDENT RIGHTS

Either the participant or his or her spouse may elect to continue their dependent children's *COBRA* continuation coverage. *COBRA* gives each covered individual the right to elect *COBRA* continuation coverage individually, i.e., you, your spouse or dependent children may elect single coverage and not include other family members who choose not to continue coverage. However, if the participant's spouse or dependent children decide to elect *COBRA* continuation coverage, they are not eligible to elect the Certified Retiree or retiree carry-over options described on pages 18 to 21 (unless he or she is the surviving spouse of a deceased participant).

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Additionally, their coverage is limited to the maximum *COBRA* continuation coverage period rather than the participant's self-pay continuation period.

A child who is born to, adopted by, or placed for adoption with a covered participant during the *COBRA* continuation period, will be eligible to become a qualified beneficiary able to individually elect *COBRA* continuation coverage. In accordance with the terms of the *Health Plan* and the requirements of federal law, these new qualified beneficiaries can be added to *COBRA* coverage upon proper and timely notification to the Health Plan Office of the birth, adoption, or placement for adoption.

Domestic partners are not individually eligible for *COBRA* continuation coverage. However, they may be enrolled as dependents of *COBRA* qualified beneficiaries.

COVERAGE OPTIONS

If you were covered under the DGA Choice Plan, the DGA Premier Choice Plan, or the HMO option immediately prior to your termination date and you elect to continue coverage under *COBRA*, you will be eligible for the plan you were in immediately prior to your qualifying event. However, the *Health Plan* permits you to choose from several different coverage options for your *COBRA* continuation coverage. These coverage options are described beginning on page 22 and include the Low Cost Plan, the *COBRA* Plan, and the *COBRA* Plus Plans. If you choose to continue coverage under the Low Cost Plan, *COBRA* Plan, or *COBRA* Plus Plans, the coverage that has been dropped cannot be reinstated. Also, if you choose not to continue coverage for your dependents, their coverage cannot be reinstated immediately (although they may individually elect *COBRA* coverage during the 60-day *COBRA* election period). You must wait until the next *open enrollment period* or you must re-qualify for *earned coverage* through employer contributions to have any dropped coverage or dependents reinstated.

PREMIUM PAYMENTS

As allowed under the law, you must pay 102% of the premium for *COBRA* continuation coverage, or in the case of a disability extension, 150% of the premium for the 19th through 29th month if the disabled individual receives the 11-month extension.

The initial premium payment (which includes payment for coverage back to your termination date) is due on your election date. However, the *Health Plan* is legally required to provide you with a 45-day grace period for this initial premium payment. No further extension will be permitted. After the initial payment, payments are due by the first of the month for the coverage period which is being paid. The *Health Plan* is legally required to provide you with a 30-day grace period for these payments. No further extension will be permitted. Payments received after your 30- or 45-day grace period will result in an automatic loss of coverage. Once coverage is lost, coverage cannot be reinstated on a self-pay basis. There are no exceptions.

SELF-PAY IN EXCESS OF COBRA

Self-pay coverage runs concurrent with the *COBRA* continuation period. However, some participants are eligible to self-pay for periods that extend beyond the minimum required under *COBRA*. The self-pay rules

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Eligibility

differ for participants who have retired and those who have not retired. In addition, changes were made to the self-pay rules effective April 1, 2002. Certain transition rules apply to participants who were on self-pay as of March 31, 2002. If you were on self-pay as of March 31, 2002, we recommend that you contact the Health Plan Office for an explanation of how those rules apply to your specific situation. The following rules apply to participants on self-pay on or after April 1, 2002.

Please note that the self-pay premiums for coverage that extends beyond the period required under *COBRA* are higher than the premiums for coverage while under *COBRA*.

Self-Pay for Participants Who Have Not Retired

Non-retired participants who have completed at least 10 years of *earned coverage* may self-pay for five years of health coverage, provided that they do not retire during that time. This means that instead of having only 18 months of *COBRA* continuation coverage, you may self-pay for up to 60 months. In addition, if you return to work and have sufficient earnings to re-qualify for *earned coverage*, you may be entitled to self-pay for another 60 months of health coverage if you later fail to qualify for *earned coverage*. If you retire during your 60 months of self-pay and are not eligible for any of the retiree self-pay rules (see below), then your right to self-pay ends at the later of: 1) your retirement date or; 2) the end of your *COBRA* coverage.

Self-Pay for Participants Who Have Retired

You may be eligible to self-pay as a retiree. This can occur with Certified Retiree coverage or retiree carry-over credits.

There are also additional self-pay rights if you retire from either of the two Directors Guild of America–Producer Pension Plans and had coverage under the *Health Plan* for two or more consecutive benefit periods immediately prior to your retirement date and had completed at least 10 years of *earned coverage* prior to retirement. In that case, you are eligible to self-pay until the later of: 1) when you reach age 65; or 2) the end of the minimum period required under *COBRA*. Any retiree carry-over credits will run concurrently with those periods.

Certified Retiree Coverage

You qualify as a Certified Retiree if you satisfy all of the following criteria:

- you retired from either the Basic or Supplemental Pension Plan; and
- you have at least 20 years of *earned coverage* prior to retirement; and
- you are at least age 60.

If you are disabled (receiving a disability pension from the Directors Guild of America–Producer Basic Pension Plan and from Social Security), the age 60 requirement does not apply, but you must still meet the other requirements.

The 20 years of *earned coverage* required for Certified Retiree eligibility may be either active *earned coverage* or inactive *earned coverage* (please see page 42). Years of *COBRA* coverage or self-pay coverage do not count towards the 20-year requirement.

If, prior to completing your 20 years of *earned coverage*, you are forced to take your retirement

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

benefits from the Basic or Supplemental Pension Plans because you have met the mandatory retirement age under pension rules, you may continue to accrue *earned coverage* years towards the 20-year requirement for Certified Retiree coverage after retirement. Your Certified Retiree coverage will begin once the 20th year has been completed.

If you do not qualify for Certified Retiree coverage under the rules explained above, it may be possible to continue your coverage in retirement on a self-pay basis.

If you qualify as a Certified Retiree, you may elect to receive health and dental coverage for a monthly premium. Dental coverage is optional. However, you cannot receive dental coverage without medical coverage. As of July 1, 2003, the monthly Certified Retiree premium rates are as follows:

CERTIFIED RETIREE COVERAGE	MONTHLY MEDICAL PREMIUM	ADDITIONAL MONTHLY PREMIUM FOR DENTAL	TOTAL MONTHLY PREMIUM FOR MEDICAL AND DENTAL
Participant Only (65 or over)	\$55.00	\$5.00	\$60.00
Participant Only (under 65)	\$90.00	\$10.00	\$100.00
Participant & Spouse (both 65 or over)	\$110.00	\$10.00	\$120.00
Participant & Spouse (one under 65, one 65 or over)	\$145.00	\$15.00	\$160.00
Participant & Spouse (both under 65)	\$180.00	\$20.00	\$200.00

Please note that the premium for a participant under 65 is higher than the premium for a participant 65 or over. This is because a Certified Retiree under 65 is generally not eligible for *Medicare*. Also, please note that there is a higher premium to receive coverage for the participant and the participant's spouse. The total amount of the premium is determined by both the participant's age and the spouse's age (i.e. whether the participant and/or spouse are 65 or over).

Participants qualifying for health coverage through Certified Retiree coverage will be covered under the DGA Premier Choice Plan, see page 32.

Children of participants on Certified Retiree coverage that were covered on June 30, 2003 are not covered by the *Health Plan*. However, the *Health Plan* has established a special rate for continuation coverage for children of retirees covered on June 30, 2003 who lost coverage on July 1, 2003. For additional information, please contact the Health Plan Office. Children of participants retiring on July 1, 2003 or later will no longer be considered eligible dependents, but are eligible to pay for continuation coverage under *COBRA*.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Eligibility

Your Certified Retiree coverage will end if:

- you do not pay your premiums on time;
- in the case of disability, the Social Security Administration determines you are no longer totally disabled. Coverage will end 30 days after the month in which the determination was made; or
- the *Health Plan* no longer provides health care coverage for its participants or eliminates Certified Retiree coverage (but not before the applicable COBRA continuation period ends).

You must enroll for Certified Retiree coverage at the time of your retirement. You must also maintain your health coverage continuously by either paying the premiums or generating earnings sufficient for *earned coverage*. **If you have a lapse in coverage, you and your spouse or domestic partner may become permanently ineligible for Certified Retiree coverage.**

Retiree Carry-Over Credits

Effective for earning periods ending September 30, 2003, if you generate at least \$21,000 in health contributions (equivalent to \$300,000 in earnings for work covered under the DGA bargaining agreements) during an earning period, you will receive a retiree carry-over credit. Retiree carry-over credits may be used to extend your coverage only after you retire and have exhausted your *earned coverage*; however, retiree carry-over credits do not count towards Certified Retiree credits. One retiree carry-over credit provides coverage for one 12-month benefit period. Retiree carry-over credits that were earned in eligibility periods ending prior to September 30, 2003 will remain unchanged.

You may use your retiree carry-over credits after your retirement to extend your health coverage under the *Health Plan*. Eligibility through retiree carry-over credits will begin at the start of the quarter on or following the later of: 1) the date your *earned coverage* ends or; 2) the date of your retirement from the Basic or Supplemental Pension Plan. Effective January 1, 2004, retiree carry-over credits can only be used at age 60 or later and upon attaining 10 years of *earned coverage*. Those participants on retiree carry-over coverage prior to January 1, 2004 who do not meet these requirements will be allowed to continue such coverage, subject to applicable premium changes.

Each retiree carry-over credit is used in full at the time that your retiree carry-over coverage begins. Therefore, if you subsequently qualify for *earned coverage* before the end of the 12-month retiree carry-over coverage period, you will not be credited for any unused retiree carry-over coverage. For example, say a participant's retiree carry-over coverage begins on July 1, 2003. If that participant subsequently qualifies for *earned coverage* beginning on January 1, 2004, retiree carry-over coverage will end on December 31, 2003 and that retiree carry-over credit is considered fully exhausted.

When you use your retiree carry-over credits, you are entitled to receive health and dental coverage for a monthly premium. Dental coverage is optional. However, you cannot receive dental coverage without medical coverage. As of July 1, 2003, the monthly retiree carry-over premium rates are as follows:

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

RETIREE CARRY-OVER COVERAGE	MONTHLY MEDICAL PREMIUM	ADDITIONAL MONTHLY PREMIUM FOR DENTAL	TOTAL MONTHLY PREMIUM FOR MEDICAL AND DENTAL
Participant Only (65 or over)	\$27.50	\$2.50	\$30.00
Participant & Spouse (both 65 or over)	\$55.00	\$5.00	\$60.00
Participant Only (under 65)	\$90.00	\$10.00	\$100.00
Participant & Spouse (one under 65, one 65 or over)	\$117.50	\$12.50	\$130.00
Participant & Spouse (both under 65)	\$180.00	\$20.00	\$200.00

Please note that the premium for a participant under 65 is higher than the premium for a participant 65 or over. This is because a participant under 65 on retiree carry-over coverage is generally not eligible for *Medicare*. Also, please note that there is a higher premium to receive coverage for the participant and the participant's spouse. The total amount of the premium is determined by both the participant's age and the spouse's age (i.e. whether the participant and/or spouse are 65 or over).

Participants qualifying for health coverage through retiree carry-over coverage will be covered under the DGA Premier Choice Plan, see page 32.

Children of participants on retiree carry-over coverage covered on June 30, 2003 are no longer covered by the *Health Plan*. The *Health Plan* has established a special rate for continuation coverage for children of retirees covered on June 30, 2003 who lost coverage on July 1, 2003. For additional information, please contact the Health Plan Office. In addition, children of participants retiring on July 1, 2003 or later will no longer be considered eligible dependents, but are eligible to pay for continuation coverage under *COBRA*.

If you have retiree carry-over credits, you do not have to enroll for Certified Retiree coverage until your eligibility from the retiree carry-over credits expires.

Your retiree carry-over coverage will end before the maximum duration of coverage if:

- you do not pay your premiums on time;
- in the case of disability, the Social Security Administration determines you are no longer totally disabled. Coverage will end 30 days after the month in which the determination was made; or
- the *Health Plan* no longer provides group health care coverage for its participants or eliminates retiree carry-over coverage (but not before the applicable *COBRA* continuation period ends).

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Eligibility

SELF-PAY BENEFITS AT A GLANCE

If you are eligible for regular self-pay coverage (i.e. not Certified Retiree or retiree carry-over coverage), you have the option of choosing between the:

- Low Cost Plan;
- COBRA Plan; or
- COBRA Plus Plans.

SELF-PAY PLAN

BENEFIT	LOW COST	COBRA	COBRA PLUS	CERTIFIED RETIREE	RETIREE CARRY-OVER
Medical	✓	✓	✓	✓	✓
Dental			✓	✓*	✓*
Prescription Drug		✓	✓	✓	✓
Wellness			✓	✓	✓
Vision			✓	✓	✓

* optional

Low Cost Plan

The Board of Trustees realizes that medical insurance is expensive, so they have developed the Low Cost Plan. This plan only provides medical coverage and has the same benefit design as the other self-pay plans except for the following:

Deductible

Individual	\$750.00
Family	\$2,250.00

Co-Insurance

	<i>Health Plan Pays</i>	<i>You Pay</i>
<i>PPO</i>	70%	30%
<i>Non-PPO</i>	50%	50%

Out-of-Pocket Maximum

	<u>(in excess of deductible)</u>
<i>PPO</i>	\$7,500.00
<i>Non-PPO</i>	\$12,500.00

The following benefits are not provided under the Low Cost Plan:

- prescription drug;
- inpatient psychiatric;
- substance abuse;
- vision;
- dental;
- *wellness benefit*; and
- special arrangements with The Industry Health Network.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

COBRA Plan

The COBRA Plan offers medical (same benefits as the DGA Choice Plan) and prescription drug coverage only. It does not cover dental benefits, vision or the *wellness benefit*.

COBRA Plus Plans

There are two COBRA Plus Plans: COBRA Plus for DGA Choice Plan participants and COBRA Plus for DGA Premier Choice Plan participants. You will be eligible for the same level of coverage as immediately prior to your qualifying event.

Changing From One Self-Pay Plan to Another

You may change your self-pay plan at your next *open enrollment period*. You also may change your plan whenever your coverage status changes – such as when there is a change in your family due to marriage, birth, adoption, or placement for adoption. At that time you may elect to continue the same coverage or choose a plan with lesser benefits. Once you elect self-pay coverage you may not switch to a more expensive plan as long as you remain on self-pay. For example, if you choose the Low Cost Plan, you may not move to the COBRA Plus Plan.

You may opt to a higher plan of benefits if you are commencing Certified Retiree coverage or coverage using retiree carry-over credits. For example, if you were on a non-retired self-pay plan and chose a plan without dental coverage, you could elect to have dental coverage when you retire as a Certified Retiree or with retiree carry-over credits.

If you are a self-pay participant or COBRA participant, the amount of your self-pay premium will be based on the amount of dependents covered and whether or not you or your eligible dependents are eligible for *Medicare*.

Self-pay premium payments can be made either monthly, quarterly, semi-annually or annually.

*Once terminated, coverage cannot be reinstated on a self-pay basis.
No exceptions are allowed!*

TERMINATION OF ELIGIBILITY

Your *earned coverage* will terminate on the earliest of the following:

- the last day of a benefit period if coverage for the following benefit period was not established during the applicable earning period; or
- the date coverage for which you were eligible is eliminated.

Earned coverage for your eligible dependents will terminate on the earliest of the following:

- the date your coverage terminates, or in the event of your death, the date coverage for your surviving spouse terminates; or
- the date the dependent ceases to meet the definition of an eligible dependent (see page 24);
- the date the Board of Trustees terminates coverage for dependents; or
- 30 days after the due date of the dependent premium, if you do not pay the premium.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Eligibility

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), when you or any of your dependents lose coverage, the *Health Plan* will send you a certificate verifying the length of your coverage. This certificate may help you obtain coverage under another plan without a pre-existing condition exclusion. If you elect self-pay continuation coverage, you and your covered dependents will also receive a coverage certificate after self-pay coverage ends. You and your dependents may request a coverage certificate within 24 months of the date coverage was lost. To make this request, contact the Health Plan Office.

MILITARY RESERVISTS

Participants with *earned coverage* who are military reservists called to active duty will have their eligibility status frozen until their release from active military duty. After release from active duty, they and their eligible dependents will receive the balance of *earned coverage* that was available to them at the time their eligibility status was frozen. Eligible dependents of such participants shall continue to be eligible under the *Health Plan* during the participant's active duty period as long as the dependent premium is paid. This provision shall expire on December 31, 2004.

■ ELIGIBLE DEPENDENTS

DEPENDENT PREMIUM

Effective October 1, 2003, if you qualify to receive *earned coverage*, payment of a dependent premium is required to receive health coverage for your spouse, domestic partner and/or eligible dependent children.

As of October 1, 2003, the dependent premium is \$600 per year per family (i.e. you do not need to remit a separate premium for each dependent). The dependent premium can be paid semi-annually (\$300 for six months) or annually (\$600 for 12 months) but will not be prorated for shorter periods of coverage. Initial payment of the dependent premium is due by the first of the month when your *earned coverage* commences. If you choose to pay semi-annually, the second semi-annual payment is due on the first day of the seventh month of your *earned coverage* (e.g. if your coverage began on January 1, your initial semi-annual payment is due January 1 and your second semi-annual payment is due July 1). There is a 30-day grace period for payment of the dependent premium.

For transition purposes only, if your *earned coverage* period commenced on any quarter prior to October 1, 2003, you may enroll your eligible dependents on October 1, 2003 and pay a prorated premium for the rest of that *earned coverage* period. Thereafter, you may only enroll your dependents during your *open enrollment period* and premiums will not be pro-rated.

If you decline enrollment for your dependents because of other health insurance coverage, you may in the future be able to enroll your dependents if you request enrollment from the Health Plan Office within 60 days after the other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

to enroll your dependents provided that you request enrollment with the Health Plan Office within 31 days after the marriage, birth, adoption, or placement for adoption. The dependent premium will not be pro-rated if you add a dependent pursuant to this paragraph.

If payment of the dependent premium is not received during the 30-day grace period, you will not be eligible to receive coverage for your dependents until the beginning of your next benefit period.

If you choose to pay the dependent premium, coverage for your eligible dependents will become effective on the date your *earned coverage* begins, or on the date you acquire the dependent, whichever is later. Eligible dependents include:

- your lawful spouse;
- your unmarried children who are younger than age 19. This includes:
 - your natural children and those of your spouse;
 - your adopted children, beginning on the date of placement for adoption; or
 - any other children dependent upon you for the majority of their financial support and living with you in a normal parent-child relationship, provided proof of these conditions can be verified;
- your unmarried children younger than age 23, provided the children are attending an accredited school on a full-time basis and are dependent upon you for the majority of their financial support and maintenance. Coverage will continue through summer vacation, or any other extended school break (spring break, semester break, etc.), if the student was full-time during the immediately preceding semester/quarter. If the dependent child does not return to school on a full-time basis immediately following the school break, coverage will end on the last day the dependent was in school;
- your unmarried children who, upon reaching age 19 (or 23 if a full-time student at an accredited school), are not capable of self-sustaining employment because of a mental or physical handicap and are considered medically to have incurred a total disability. The child's mental or physical handicap must have existed while the child was eligible for coverage and before the child reached the age limit. In addition, the child must be primarily dependent upon you for support and maintenance; and
- your same sex domestic partner. Eligibility and benefits for domestic partners are similar to, but not the same as, spousal benefits. Most taxing authorities do not currently recognize domestic partners as eligible dependents. Therefore, the benefits offered to domestic partners are considered taxable compensation and the *Health Plan* is required by law to collect taxes on these benefits. Please contact the Health Plan Office for an information packet.

Your unmarried children between ages 19 and 23 and enrolled in an accredited school on a full-time basis are covered only if you send us a Student Verification Form from the school semi-annually.

Eligibility

Newly acquired children of participants who have *earned coverage* are covered for the first 31 days after birth, adoption or placement for adoption, but lose coverage unless the *Health Plan* is notified of the birth, adoption or placement for adoption, and the applicable dependent premium is remitted to the Plans. However, if you have already paid the dependent premium for your existing dependents, you do not need to submit an additional premium for the new child.

Newly acquired children of participants who have coverage through any of our self-pay programs are covered for the first 31 days after birth, adoption or placement for adoption, but lose coverage unless the *Health Plan* is notified of the birth, adoption or placement for adoption, and arrangements are made to include the child in the self-pay program, including remittance of an additional premium, if necessary.

Dependents do not include parents or any relatives other than those described in this section.

If you have a Qualified Medical Child Support Order, you may be required to cover your eligible dependent children under the *Health Plan*. Upon receipt of an order purporting to be a Qualified Medical Child Support Order, the Health Plan Office will follow the procedures established for reviewing and implementing such orders with respect to coverage under the *Health Plan*. You may request, at no charge, a copy of such procedures from the Health Plan Office.

VERIFYING ELIGIBLE DEPENDENTS

In order to verify eligibility, promptly send the Health Plan Office a copy of the following documents:

RELATIONSHIP/ CIRCUMSTANCE	DOCUMENT
Spouse / Marriage	A copy of the certified marriage certificate
Child / Birth	A copy of child's certified birth certificate
Ex-spouse / Divorce	A copy of the final divorce decree
Child / Adoption and Guardianship	A copy of the adoption or guardianship documents
Child / Student	A student verification form must be completed by the Registrar's Office of the accredited school. This verification form must be submitted semi-annually for the following two eligibility periods: October 1 to January 31 and February 1 to September 30. The school must indicate that the student is enrolled as a full-time student and give the start and end dates of the school term.
Child / Physically or Mentally Disabled	A copy of the attending physician's history, physical report and proof of total disability. Proof that you are providing at least half of your dependent's support must also be provided.
Same Sex Domestic Partner	A signed affidavit (available from the Health Plan Office). Among other things, the affidavit requires that the couple resides together and has a mutual financial support as if married. There is no domestic partner coverage for opposite sex non-married couples.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

We realize that it can take time to obtain a certified marriage or birth certificate. When you marry or give birth, you may send us an uncertified copy as temporary documentation, but we will require a certified copy within three months.

DROPPING YOUR DEPENDENT'S COVERAGE

If you are a self-paying participant or a participant with *earned coverage* paying the dependent premium, you may voluntarily drop your dependents from your coverage during your open enrollment period.

A dependent voluntarily dropped from self-pay coverage or *earned coverage* can only be added back onto your coverage during your *open enrollment period*.

In cases of involuntary loss of a dependent's coverage (such as death, divorce, over-age, etc.) notification must be given within 60 days. Please refer to page 15 for information concerning these notice requirements.

Remember: You must notify the *Health Plan* of the loss of a dependent's coverage. If you fail to do so in a timely manner, you will be responsible for reimbursing the *Health Plan* for any claims paid on behalf of your dependent during the period that the dependent should not have been covered.

DUAL COVERAGE

If you and your spouse are each eligible as a participant in the *Health Plan*, please refer to page 40 for further details regarding coordination of benefits.

COVERAGE EXTENSIONS

COVERAGE EXTENSION DURING TOTAL DISABILITY

If you or a dependent has a total disability on the date your coverage is canceled, medical benefits will be continued for treatment of the disabling condition only until the earliest of the following:

- 12 months from the date premium payment ceased for you or your dependent;
- the date that the maximum amount of benefits have been paid;
- the date that you or your dependent ceases to be totally disabled; or
- the date that coverage for you or your dependent becomes effective under any replacement policy which does not exclude the disabling condition.

*Only benefits for the sickness or injury that caused the total disability are continued.
No benefits are payable with respect to any other sickness or injury.*

EXTENSION OF DENTAL COVERAGE

Please see the Dental Plan portion of this booklet for an explanation of a special dental coverage extension.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Eligibility

COVERAGE EXTENSIONS IF YOU DIE

If you die, your surviving eligible dependents will be covered based on whatever coverage you had in effect on the date of your death.

Dependents of Participants with Earned Coverage

Your surviving spouse will be covered for the remainder of any *earned coverage* you had accumulated before your death. Carry-over credits may be used to meet the requirement for *earned coverage*. Please note that the dependent premium is still due on behalf of a surviving spouse and/or any dependent children covered under your coverage.

After this extension terminates, your surviving spouse is entitled to continue coverage by self-paying for the longer of:

- the number of benefit periods that would have been available to you on a self-pay basis if you lost *earned coverage*; or
- the *COBRA* continuation period described on page 15.

Surviving dependent children will be covered with your surviving spouse for as long as they satisfy the definition of an eligible dependent (see page 24) and payment of the dependent premium is made on their behalf. If there is no surviving spouse, eligible dependent children will remain covered until the end of the current earned benefit period. Following this, coverage may be continued by making payments in accordance with *COBRA*. Please refer to *COBRA* continuation coverage on page 15 for additional information.

Dependents of Self-Pay Participants

Your surviving spouse is entitled to continue coverage by making self-payments for the longer of:

- the number of remaining benefit periods that were available to you on a self-pay basis; or
- the remaining *COBRA* continuation period described on page 15.

Surviving dependent children will be covered with your surviving spouse for as long as they satisfy the definition of an eligible dependent (see page 24). If there is no surviving spouse, eligible dependent children may continue coverage by making payments in accordance with *COBRA*. Please refer to *COBRA* continuation coverage on page 15 for additional information.

Dependents of Retirees

Dependent children of retirees on self-pay, retiree carry-over, regular carry-over and Certified Retiree coverage are not covered by the *Health Plan*. If a retiree has *earned coverage* by virtue of current employment or residuals, eligible children will be covered if the premium is paid. However, eligible dependent children that were covered on June 30, 2003 and ceased to be eligible on July 1, 2003 are eligible for continuation coverage. For additional information regarding the special self-pay rate for dependent children of retirees as of July 1, 2003, please contact the Health Plan Office.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

A surviving spouse of a retiree on self-pay, retiree carry-over and Certified Retiree coverage may continue receiving coverage at the applicable premium rates. Please note that the amount of the Certified Retiree and retiree carry-over premiums for a surviving spouse are determined by the surviving spouse's eligibility for *Medicare*.

► **CONVERSION OF COVERAGE**

When your *earned coverage* or self-pay coverage ends, participants in California may be able to convert their coverage to an individual policy separate and apart from the *Health Plan's* policy. Conversion coverage for participants outside of California is not currently available. Dental and vision care coverage cannot be converted. If you qualify for conversion of coverage and make this change within 31 days of becoming eligible for it, you will not have to take a medical exam or provide evidence of insurability. You should note that this converted policy may not offer the same comprehensive benefits and may be subject to a higher premium rate.

If you or a dependent intends to convert coverage, we recommend that you check with the Health Plan Office for more information about who can convert and how to contact the provider of conversion coverage.

Medical Plan

- DGA Choice and DGA Premier Choice
- Some general terms
- Using a PPO provider
- The Industry Health Network and The Motion Picture and Television Fund
- Sharing the cost of medical care
- Coordination of benefits
- Medicare and plan benefits
- What's covered under the Medical Plan
- What's not covered under the Medical Plan

The Medical Plan

Generally, the Medical Plan portion of the *Health Plan* describes the covered medical benefits. However, if you reside in California, you may be able to elect a health maintenance organization (HMO) option in lieu of the Medical Plan. If applicable, you must choose between the Medical Plan and the HMO option during your *open enrollment period*. This election is then effective for your entire 12-month benefit period and may not be changed until your next *open enrollment period*. For a description of the benefits provided under the HMO option, refer to the HMO Summary of Benefits and Evidence of Coverage, which are available upon request from the Health Plan Office and are incorporated here by reference.

The Medical Plan is what is known as a “comprehensive” medical plan. It is easy to understand because *covered expenses* are all treated the same way—whether they’re hospital-related or not. The *Health Plan* covers a wide range of medical services, including some alternatives to traditional acute care. In most states, you have the choice between receiving services through a preferred provider organization (PPO) or providers you choose on your own.

DGA CHOICE AND DGA PREMIER CHOICE

There are two levels of benefits under the *Health Plan*: DGA Choice and DGA Premier Choice.

If you generate contributions on *covered earnings* between the minimum for *earned coverage* and \$90,000 during your earning period, you will be covered under the DGA Choice Plan. If you generate contributions on *covered earnings* of \$90,000 or more during your earning period, you will be covered under the DGA Premier Choice Plan. Participants who receive coverage as a result of regular carry-over credit will be covered under the DGA Choice Plan. Participants who receive coverage under *COBRA* will be covered under the plan that they were participating in immediately before their qualifying event (but may choose a lesser coverage). Participants and surviving spouses who are covered under retiree carry-over and Certified Retiree coverage will be covered under the DGA Premier Choice Plan. The following chart shows which participants will be covered under which plan:

IF YOUR COVERAGE IS BASED ON:	YOU ARE COVERED UNDER THE
Contributions on covered earnings of \$27,900*–\$89,999.99	DGA Choice Plan
Contributions on covered earnings of \$90,000 or more	DGA Premier Choice Plan
Carry-over credit	DGA Choice Plan
Certified Retiree	DGA Premier Choice Plan
Retiree carry-over credit	DGA Premier Choice Plan

*\$27,900 is the minimum earnings threshold for benefit periods beginning on January 1, 2003. \$28,700 will be the minimum earnings threshold for benefit periods beginning on January 1, 2004. The minimum earnings threshold generally increases every January 1.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The differences in the levels of benefits between the DGA Choice Plan and the DGA Premier Choice Plan are detailed in the sections of this booklet that describe the benefits offered by the *Health Plan*.

► SOME GENERAL TERMS

Before you read the details of the Medical Plan, you should familiarize yourself with a few of the basic concepts of the *Health Plan*. The following explains a few terms that affect your coverage.

Preferred Provider Organization (PPO) — *PPO* providers are doctors and *hospitals* that have agreed to charge a reduced rate when used by *Health Plan* participants. For California, *PPO* providers are associated with Blue Cross of California. Outside California, *PPO* providers are associated with Private Healthcare Systems (“PHCS”).

Deductible — The deductible refers to the amount of *covered expenses* you must pay before the *Health Plan* will pay any benefits. The deductible is applied on a calendar year basis. Details of the medical deductible are on page 37 and details of the dental deductible are on page 63.

Co-insurance — The co-insurance is the amount that you pay once the annual deductible has been met. The co-insurance may be the percentage you pay as your share of the *covered expenses*, such as 10% of *PPO* expenses, or a flat dollar amount, such as \$10 for generic prescriptions. For a full explanation, please see page 38.

Out-of-Pocket Limit — The out-of-pocket limit is the maximum amount of *covered expenses* that a participant is required to pay after deductibles and co-payments. For example, once a participant pays \$1,000 in out-of-pocket *PPO* expenses after deductibles and co-payments, the remainder of *covered expenses* for that year are paid by the *Health Plan*. In this example, \$1,000 is the out-of-pocket limit. Please note that the out-of-pocket limit is higher for non-*PPO* expenses. Also, there is a separate out-of-pocket limit for each family member. Further details can be found beginning on page 38.

Stop-Loss — The stop-loss is the total amount of *covered expenses*, after deductibles and co-payments, at which time the *Health Plan* pays 100% of *covered expenses*. For example, once a participant incurs a total of \$10,000 in *PPO covered expenses* (the *PPO* out-of-pocket limit is \$1,000 for both DGA Choice and DGA Premier Choice members) after deductibles and co-payments, the *Health Plan* will pay the remainder of *covered expenses* for that year. In this example, the stop-loss is \$10,000. Please note that the stop-loss is higher for non-*PPO* expenses in the DGA Choice Plan. Also, there is a separate stop-loss limit for each family member. Further details can be found beginning on page 39.

Allowable Charge — The *allowable charge* is the amount that the *Health Plan* will consider for each medical procedure or service. For some procedures and services, the *allowable charge* is based on the *reasonable and customary charge*. For other procedures and services, it is based upon an amount set by the *Health Plan*. For example, the maximum *allowable charge* for *chiropractic care* is \$50 per visit.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

USING A PPO PROVIDER

In California, the *PPO* network provider is Blue Cross of California. Outside California, the *PPO* network provider is Private Healthcare Systems, Inc. (PHCS). Both you and the *Health Plan* save money when service is provided by a *PPO* provider. Using a *PPO* provider benefits you in several ways:

- *PPO* providers have agreed to charge a fixed, reduced rate;
- the *Health Plan* pays 90% of covered *PPO* charges versus 70% (DGA Premier Choice Plan) or 60% (DGA Choice Plan) of covered non-*PPO* charges;
- assignment of benefits (the provider bills the *Health Plan* directly);
- the provider should not charge more than the *Health Plan* negotiated rate; and
- strict accreditation and credentialing requirements of providers.

Using a *PPO* provider does not require special enrollment. All you have to do is choose to receive medical care from one of the doctors or other health care providers listed on the Blue Cross (in California) or PHCS (outside California) websites (www.bluecrossca.com or www.phcs.com). In addition, you may call both Blue Cross at (800) 888-4825 or PHCS at (888) 847-7427. You may request, at no charge, a list of providers from the Health Plan Office.

What's My PPO?

CALIFORNIA	OUTSIDE CALIFORNIA
Blue Cross of California	Private Healthcare Systems (PHCS)

When you need *hospital* care, you can choose a *hospital* that participates in our *PPO* network (Blue Cross in California, PHCS outside California). Please note, however, that even though you use a *PPO hospital*, all services might not be performed by *PPO* providers. For example, the *hospital* and surgeon may be *PPO* providers but the anesthesiologist might not be. When a referral is necessary, you should ask for a referral to another *PPO* provider. However, please note that your doctor is not required to refer you to a *PPO* provider and, if you wish to stay within the *PPO* network, you are responsible for confirming that any doctor that you have been referred to is a *PPO* provider.

If you use a *PPO* provider, the cost savings is mutually beneficial to you and the *Health Plan*. Working together to save on health care costs will help us continue providing our participants with high quality benefits.

You should note that using a *PPO* doctor or *hospital* does not necessarily mean that the treatment is covered. Nor does "approval" from the doctor, *hospital* or the *PPO* guarantee coverage. For example, a non-covered service, such as cosmetic surgery, performed by a *PPO* doctor is not covered. To be sure that a procedure or treatment is covered, you should contact the Health Plan Office.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

PPO PHYSICIANS AND HOSPITALS:

For California, Blue Cross of California provides the PPO network. Please call (800) 888-4825 or use the provider finder at www.bluecrossca.com to determine if the physician or hospital is in the Blue Cross Network.

Outside California, PHCS provides the PPO network. Please call (888) 847-7427 or use the provider finder at www.phcs.com to determine if the physician or hospital is in the PHCS Network.

NOT ALL AREAS HAVE THE PPO

Some areas do not have PPO providers. Nevertheless, the *Health Plan* is continuously working to expand the PPO network to all areas. If you live in an area where no PPO exists, or where PPOs are not allowed, benefits will be paid at the regular non-PPO rate of 70% (DGA Premier Choice Plan) or 60% (DGA Choice Plan) of *allowable charges*.

THE INDUSTRY HEALTH NETWORK AND THE MOTION PICTURE AND TELEVISION FUND

THE INDUSTRY HEALTH NETWORK

The Industry Health Network (TIHN) is a wholly-owned subsidiary of The Motion Picture and Television Fund (MPTF). Through a special arrangement between the *Health Plan* and MPTF, you may use any of the outpatient facilities listed below:

Bob Hope Health Center
335 North La Brea Avenue
Los Angeles, CA 90036-2584
(323) 634-3850

Monday–Friday: 8:30 a.m. - 5:00 p.m.

Santa Clarita Health Center
25751 McBean Parkway, Suite 210
Valencia, CA 91355-3701
(661) 284-3100

Monday–Saturday: 8:30 a.m. - 5:00 p.m.

Toluca Lake Health Center
4323 Riverside Drive
Burbank, CA 91505-4044
(818) 556-2700

Monday–Thursday: 7:00 a.m. - 7:00 p.m.

Friday: 7:00 a.m. - 6:00 p.m.

Saturday: 8:30 a.m. - 5:00 p.m.

Westside Health Center
1950 Sawtelle Boulevard, Suite 130
Los Angeles, CA 90025-7014
(310) 996-9355

Monday–Friday: 8:30 a.m. - 5:00 p.m.

Saturday: 9:00 a.m. - 1:00 p.m.

Woodland Hills Health Center
23388 Mulholland Drive
Woodland Hills, CA 91364-2733
(800) 876-8320
(818) 876-1050

Monday–Friday: 7:30 a.m. - 9:00 p.m.

Saturday & Sunday: 9:00 a.m. - 4:00 p.m.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

When you use a TIHN facility and a TIHN primary care physician (PCP), you have a set co-payment, usually \$10. For hospitalization, you will pay the regular 10% co-insurance. Referrals from a TIHN PCP have the same co-payments as the TIHN facilities.

If you use a TIHN facility and PCP, your co-payments are as follows:

BENEFITS THROUGH A TIHN FACILITY AND PCP	CO-PAYMENT
Primary Care Visits	\$10
Specialist Visits, referred by your PCP	\$10
Well Child Care	\$10
Pediatric Visits	\$10
Physical Therapy	\$10
Surgery, including Assistant Surgeon* (Inpatient and Hospital-based outpatient)	\$100

*Does not include hospitalization fees.

To use TIHN, make an appointment at one of the five TIHN health centers to see a PCP. The PCP will then monitor your care and make any necessary referrals to specialists or ancillary services (laboratory, radiology, etc.). All referrals must be made by your PCP.

TIHN has over 500 specialists to provide support to the PCPs for consultation purposes and contracts with the following Southern California *hospitals* for inpatient care and outpatient support:

Motion Picture and Television Hospital — Woodland Hills
Cedars-Sinai Medical Center — Los Angeles
Providence – Saint Joseph Medical Center — Burbank
Saint John's Hospital and Health Center — Santa Monica
Henry Mayo Newhall Memorial Hospital — Valencia

Comprehensive Physical Exam at One of the Five TIHN Health Centers

An often overlooked benefit of both the DGA Choice Plan and the DGA Premier Choice Plan is the free comprehensive physical exam offered through TIHN. There is no deductible or co-payment for this benefit for eligible participants. If you are over age 40 and use one of the five Industry Health Network centers, you can receive a physical exam once every 12 months. For participants and covered spouses between ages 19 and 40, the exam is provided once every 24 months. Dependent children are not eligible for this benefit, but are covered under well child care or the *wellness benefit*, depending on age.

The doctor will ask you general questions regarding your lifestyle and health habits, perform a general exam, check your blood pressure, cholesterol levels and order routine blood tests. Pap smears and mammograms are available for women. Prostate cancer screening is available for men.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Afterward, your *physician* will review the results of the examination with you, giving you recommendations that address your specific needs. If a health concern is discovered in the course of the exam, your *physician* will generally ask you to schedule a return visit so that he or she can provide further care. These additional services are not part of the comprehensive physical exam and would be charged separately.

To schedule a comprehensive physical exam, please call one of the five TIHN health centers (listed on page 35 and at www.mptvfund.org) for an appointment.

Physical exams are only available through TIHN, except as provided in the wellness benefit. See page 53

SHARING THE COST OF MEDICAL CARE

You share in the cost of your health care in five ways:

1. the deductible, which is the amount you satisfy before the *Health Plan* begins paying for *covered expenses*;
2. co-insurance, which is the percentage you pay as your share of *covered expenses*;
3. co-payments, which are set fees paid when receiving certain benefits;
4. the dependent premium; and
5. the expenses in excess of the *reasonable and customary charge*.

HOW THE DEDUCTIBLE WORKS

Before benefits are payable to you, you must satisfy the calendar year deductible. The calendar year deductible is \$300 for an individual, and \$900 for a family. Your family deductible is “cumulative” and is considered satisfied when *covered expenses* for three or more family participants meet the annual \$900 deductible. When this occurs, the deductible amounts applied toward other family participants will be adjusted. The deductible is the same whether or not you use a *PPO* provider. The deductible is the same for both the DGA Premier Choice Plan and the DGA Choice Plan.

NOTE: Your deductible applies to both doctor and *hospital* expenses, as well as all other related expenses that are covered under the *Health Plan*. The Dental Plan and Vision Plan have separate deductibles. Prescription drug, emergency room, non-*PPO hospital* and TIHN co-payments do not count toward the Medical Plan deductible.

If you have coverage as an individual, the deductible is \$300 per calendar year. Once you have \$300 in *covered expenses*, the *Health Plan* will pay benefits on *covered expenses* above that amount.

If you have coverage for yourself plus one dependent, the deductible is \$300 per individual per calendar year. Once an individual has \$300 in *covered expenses*, the *Health Plan* will pay benefits on *covered expenses* above that amount for that individual.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

When you have coverage for yourself plus two or more dependents, the deductible works as follows:

- if three or more covered family participants meet a combined deductible amount of \$900 in one calendar year, no further deductibles will be charged to the family for that year; or
- if one family member has \$300 of *covered expenses* in the calendar year, no further deductible will be charged to that family member, but there is a \$600 deductible amount remaining for the rest of the family.

There is also a special deductible “carry-over” provision that applies to everyone enrolled in the *Health Plan*. If you have medical expenses in the last quarter of the calendar year (October, November and December) that apply toward meeting this year’s deductible, those medical expenses will be “carried over” and applied to next year’s deductible. For example, if you have eligible expenses of \$100 in December which apply toward your deductible, you will only need another \$200 after January 1 to satisfy the deductible for the new year.

YOUR CO-INSURANCE

Once you satisfy the annual deductible, the *Health Plan* shares *reasonable and customary charges* with you as shown in the chart below:

	DGA PREMIER CHOICE PLAN		DGA CHOICE PLAN	
	PPO	Non-PPO	PPO	Non-PPO
Plan Pays	90%	70%	90%	60%
You Pay	10%	30%	10%	40%

You are responsible for any charges in excess of the *reasonable and customary charges* and all *non-covered expenses*. PPO providers should not charge more than their special negotiated fee for *covered expenses*.

OUT-OF-POCKET LIMIT/STOP-LOSS

The Medical Plan limits the amount you have to pay for *covered expenses* in any calendar year, after your annual deductible is satisfied, by placing an “out-of-pocket” limit and a “stop-loss” on *covered expenses*. The out-of-pocket limit refers to the maximum amount of *covered expenses* a participant is required to pay in a calendar year. The stop-loss refers to the total amount of *covered expenses* incurred during a calendar year at which the *Health Plan* begins to pay 100% of *covered expenses*.

The out-of-pocket limit is the maximum amount of *covered expenses* that a participant is required to pay after deductibles and co-payments. The out-of-pocket limit for PPO expenses for both the DGA Premier Choice Plan and the DGA Choice Plan is \$1,000. The out-of-pocket limit for non-PPO expenses for the DGA Premier Choice Plan is \$3,000. The out-of-pocket limit for non-PPO expenses for the DGA Choice Plan is \$7,500. There is a separate out-of-pocket limit for each family member.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

The stop-loss is the total amount of *covered expenses*, after deductibles and co-payments, at which point the *Health Plan* pays 100% of *covered expenses*. The stop-loss for *PPO* expenses for both the DGA Premier Choice Plan and the DGA Choice Plan is \$10,000. The stop-loss for non-*PPO* expenses for the DGA Premier Choice Plan is also \$10,000. The stop-loss for non-*PPO* expenses for the DGA Choice Plan is \$18,750. There is a separate stop-loss for each family member.

The out-of-pocket limit and the stop-loss are directly related to each other. For example, the stop-loss for *PPO* expenses (for both DGA Premier Choice and DGA Choice participants) is \$10,000. After deductibles and co-insurance, the *Health Plan* pays 90% of covered *PPO* expenses (\$9,000) and the remainder of *covered expenses* (\$1,000) are paid by the participant. This remainder of covered expenses paid by the participant (\$1,000) is the participant's out-of-pocket limit.

A new stop-loss and out-of-pocket limit begin each calendar year and apply separately to each family participant.

NOTE: The deductibles, out-of-pocket limit and stop-loss are higher under the Low Cost Plan, but work in the same manner.

OUT-OF-POCKET LIMIT

	PPO	Non-PPO
DGA Premier Choice Plan	\$1,000	\$3,000
DGA Choice Plan	\$1,000	\$7,500

STOP-LOSS

	PPO	Non-PPO
DGA Premier Choice Plan	\$10,000	\$10,000
DGA Choice Plan	\$10,000	\$18,750

Certain expenses do not count towards reaching the out-of-pocket limit and stop-loss. These include:

- *Non-covered expenses*;
- Deductibles;
- Charges in excess of *reasonable and customary charges*;
- Prescription drug expenses;
- Dental benefits;
- Vision benefits, including glasses and contact lenses;
- *Non-PPO hospital* co-payments;
- Emergency room co-payments;
- Charges, including co-payments, incurred at a The Industry Health Network facility;
- Inpatient psychiatric and substance abuse expenses; and
- Outpatient psychotherapy.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

LIFETIME MAXIMUM

The lifetime maximum in paid benefits for all *sicknesses* or *injuries* is \$2,000,000 per individual. Substance abuse benefits are limited to a lifetime maximum of \$30,000. Vision and dental benefits do not count towards the \$2,000,000 lifetime maximum. The lifetime maximum is \$2,000,000 whether or not there has been an interruption in coverage.

If your \$2,000,000 lifetime maximum is reached, your maximum will be increased by \$5,000 on the first day of the next calendar year. In subsequent years, your maximum will be increased by the amount of medical benefits you received in the prior year up to \$5,000. In no event will the lifetime maximum be increased by more than \$5,000 in any given year. This yearly increase does not apply to the \$30,000 substance abuse maximum.

COORDINATION OF BENEFITS

In many families, both husband and wife work. Each may be covered by a group health plan and each may include the other as a dependent. The plan covering a participant pays first, and the plan covering the dependent pays second.

Coordination of benefits is simply a way of dividing responsibility for payment among the separate health plans that cover an individual. Charges include all items of care covered under at least one of the plans. Types of plans with which the *Health Plan* coordinates benefits include:

- group insurance coverage;
- government-provided programs;
- coverage provided by statute;
- employer-sponsored Blue Cross/Blue Shield or other pre-payment coverage; and
- any coverage under labor-management trustee plans or employer benefit organization plans.

For dependents, the primary plan is determined as follows:

1. The plan without a coordination provision is always primary.
2. If the claim is for a child, submit the claim to the plan of the parent whose birthday falls earlier in the year, then to the other parent's plan. If both parents have the same birthday, submit the claim to the plan which covered the parent longer.
3. If the claim is for a child of divorced or separated parents, submit the claim to the plan of the parent with custody, then to the plan of the spouse of the parent with custody, and finally to the plan of the parent not having custody. Notwithstanding the foregoing, if the divorce settlement is different, court rulings will be followed. A copy of the court ruling will be required.
4. The plan covering the person as an active employee pays benefits before the plan covering the person as an inactive, laid-off, self-pay or retired employee. The plan covering the person as the dependent of an active employee pays benefits before the plan covering the person as an inactive, laid-off, self-pay or retired employee.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

There is also coordination of benefits when a participant has coverage under one or more of his or her own plans. An example of this is a participant who has *earned coverage* under both the *Health Plan* and also the Screen Actors Guild–Producers Health Plan. In processing claims where two or more plans are involved, the *Health Plan* follows the “Primary-Secondary Rule.” The plan under which you have had the longest, continuous eligibility as a participant is your primary plan and pays benefits first. If you have the same effective date in both plans, each plan is responsible for 50% of the *allowable charges*.

Once responsibility for first payment is established, the *Health Plan* proceeds in one of two ways:

1. If the *Health Plan* is the primary plan, we determine and pay benefits in the regular manner, with no consideration of what the secondary plan may or may not pay.
2. If the *Health Plan* is the secondary plan, we begin by determining how much we would have paid had there been no other group coverage. Next we find out what the primary plan paid. Then we make a payment for the difference, if any, between the total allowable expense and the amount paid by the primary plan, but not to exceed the liability under our own coverage.

For example:

IF THE HEALTH PLAN IS PRIMARY		IF THE HEALTH PLAN IS SECONDARY	
\$500	Allowable Charges (PPO)	\$500	Allowable Charges
<u>x 90%</u>		<u>-400</u>	Primary Plan Pays 80%
\$450	The Health Plan Will Pay	\$100	The Health Plan Will Pay
\$50	You Pay	\$0	You Pay

These examples assume that the annual deductible has been met.

THE DEPENDENT PREMIUM AND COORDINATION OF BENEFITS

In a case where both a husband and wife each qualify for *earned coverage* from the *Health Plan*, the dependent premium must be paid by each participant in order to receive full coordination of benefits. If no dependent premium is paid, both husband and wife are covered as participants under their own coverage, but will not be covered as a dependent under their spouse’s coverage and there will be no coordination of benefits. If both husband and wife pay the dependent premium, they will each be covered as a participant under their own coverage and as a dependent under their spouse’s coverage and will receive full coordination of benefits. Similarly, if only one spouse pays the dependent premium, the spouse paying the premium will be covered only as a participant and the spouse not paying the premium will be covered as both a participant and a dependent.

Dependent children are treated in a similar manner. If a husband and wife both qualify for *earned coverage* from the *Health Plan*, but only one spouse pays the dependent premium, the dependent children will be covered only under the health coverage of the participant that paid the dependent premium and will

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

receive no coordination of benefits. If both participants pay the dependent premium, the dependent children will be covered under the health coverage of both participants and will receive full coordination of benefits. In a case where both participants qualify for *earned coverage* and both pay the dependent premium, the coverage of the participant whose birthday falls earlier in the year will be considered primary and the coverage of the participant whose birthday falls later in the year will be considered secondary. If both parents have the same birthday, the coverage of the parent that has been covered longer under the *Health Plan* will be considered primary.

■ MEDICARE AND PLAN BENEFITS

Medicare is a Federal health insurance program for people age 65 and over, and many disabled persons. It is administered by the Centers for Medicare and Medicaid Services (CMS). You can find extensive information about *Medicare*, including how to enroll, at www.medicare.gov.

For participants eligible for *Medicare*, benefits are payable by both the *Health Plan* and *Medicare*. If you are entitled to benefits under *Medicare*, whether or not you enroll, you will be deemed to have enrolled for purposes of determining which plan is primary.

Remember! You must be enrolled in both Medicare Part A and Part B to receive full reimbursement for your hospital and doctor bills.

ACTIVE AND INACTIVE PARTICIPANTS

Federal law requires that the *Health Plan* be primary to *Medicare* for active participants. The type of earnings that are reported to the *Health Plan* on your behalf will determine whether you are considered an active participant. The rules are as follows:

1. If you have earnings of \$27,900* or more for covered work (current employment or non-residuals), you are considered active and the *Health Plan* is the primary payor.
2. If you have earnings of \$27,900* or more solely from residuals, or if you have used any carry-over money to maintain *earned coverage*, you are considered inactive and *Medicare* is primary payor.
3. If your earnings are comprised of both current employment and residuals but less than \$27,900* is from current employment, you are considered inactive and *Medicare* is primary payor.

* \$27,900 is the 2003 minimum earnings requirement. This amount will increase to \$28,700 on January 1, 2004, and generally increases every January.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

The following chart outlines these rules:

COVERAGE BASED ON	PRIMARY PLAN	SECONDARY PLAN
\$27,900* non-residual earnings	DGA-PHP	Medicare
\$27,900* residual earnings	Medicare	DGA-PHP
\$27,900* combination of non-residuals and residuals but less than \$27,900* non-residual employment	Medicare	DGA-PHP
Carry-over credit	Medicare	DGA-PHP
Combination of current and carry-over but less than \$27,900* current	Medicare	DGA-PHP
Retiree carry-over credits	Medicare	DGA-PHP

Medicare is primary and the *Health Plan* is secondary when you have less than \$27,900* in current active employment because *Medicare* does not consider residual income or carry-over credit as active employment.

*\$27,900 is the 2003 minimum earnings requirement. This amount will increase to \$28,700 on January 1, 2004, and generally increases every January 1.

NOTE: If you have health coverage under *Medicare* and under another plan that supersedes the *Health Plan* coverage under the coordination of benefits rules (see page 41), then the *Health Plan* may be tertiary, rather than secondary.

RETIRED PARTICIPANTS

Medicare is considered primary and the *Health Plan* is secondary for retired participants who are also eligible for *Medicare* and retired participants' eligible dependent spouses who are eligible for *Medicare*. All Medical Benefits will be coordinated with Parts A and B of the *Medicare* program. Part A is *Medicare's* hospital insurance; Part B is *Medicare's* medical insurance.

If, however, a retiree returns to work and becomes eligible as an active participant based upon eligibility earned through *covered earnings*, the participant, as well as an eligible spouse who is covered under *Medicare*, will be treated as an active participant for the purpose of coordinating medical benefits with *Medicare*. There will be no coordination of benefits for the spouse if the dependent premium is not paid by the participant.

In order to coordinate with *Medicare* payments, the *Health Plan* will need the Explanation of Benefits (EOB) form sent by *Medicare* to each patient. Make sure the participant's name and Social Security number are on the form, attach it to the matching bill and forward it to the Health Plan Office.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

DOCTORS WHO DO NOT PARTICIPATE IN MEDICARE

If you go to a doctor that does not participate in *Medicare* or has contracted out of *Medicare*, and *Medicare* is your primary plan, the *Health Plan* will compute your benefits as if you had received reimbursement for your medical expenses from *Medicare* first. That is, for most procedures the *Health Plan* will pay whatever the *Health Plan* would have paid had the doctor participated in *Medicare*. For example, when *Medicare* pays 80% of the *Medicare*-allowed charges, the *Health Plan* will continue to cover the remaining 20%, subject to the annual deductible and other *Health Plan* limitations. This means that a participant choosing to use a non-*Medicare* participating provider will have substantially higher medical costs. Not only will 80% not be covered at all by *Medicare* or the *Health Plan*, but the 20% that we cover is only 20% of the *reasonable and customary* amount, which may be lower than the doctor's charges. Typically, a non-*Medicare* participating provider charges more than the *Medicare* allowance.

If *Medicare* is your primary plan, the *Health Plan* is secondary, and you go to a non-*Medicare* participating provider, the *Health Plan* will cover you as if *Medicare* is primary.

Part A and Part B

Medicare is a two-part program. Part A, which covers hospitalization and certain follow-up services, is free of charge to eligible retirees. Part B, which helps pay doctor bills and other medical bills involves a monthly premium. In order for you to receive optimum coverage and reimbursement for your *hospital* and doctor bills, it is important that you enroll in both *Medicare* Part A and Part B.

Important: If you and/or your spouse are eligible for *Medicare* and fail to enroll in *Medicare* Part A and Part B, you will not receive full reimbursement for your *hospital* and doctor bills. You should be aware that the *Health Plan* computes benefits as if you are enrolled in both Part A and Part B, and will coordinate benefits as though you had received reimbursement for your medical expenses from *Medicare*.

WHAT'S COVERED UNDER THE MEDICAL PLAN

The Medical Plan covers a wide range of services, including those discussed here. If you have a *hospital* or *physician* expense that is not specifically listed here, call the Health Plan Office and the staff will help you determine whether or not the expense is covered. The *Health Plan* does not have a pre-existing condition exclusion clause.

Once you satisfy the deductible, the *Health Plan* will pay the appropriate percentage of reasonable and customary charges that are required to treat a *sickness* or *injury*. All care must be *medically necessary*.

ACUPUNCTURE

Acupuncture is covered for up to 20 visits per individual per calendar year. The maximum *allowable charge* for *acupuncture* treatment is \$85 per visit.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

AMBULANCE SERVICE

Licensed ambulance company service is covered for emergency transportation to or from a local *hospital*.

In the event that specialized treatment is needed at a specially equipped *hospital*, and a ground ambulance is not available or practical, or if you should have an *accident* or medical emergency in an area not easily accessible by conventional transportation, coverage is provided for air transportation to the nearest facility equipped to provide the necessary services. Transportation for patient/doctor convenience is not covered.

AMBULATORY SURGICAL CENTER

PPO ambulatory surgical centers are covered at the usual *PPO* rate. *Non-PPO ambulatory surgical centers* are covered only up to 25% of the *reasonable and customary* allowance for the surgical procedure performed.

BIRTHING CENTER

A birthing center is a facility established to manage low risk, normal, uncomplicated pregnancy with delivery within 24 hours of admission to the center. It must be licensed by the state (if required by the state) as a birthing center.

As an alternative to traditional *hospital* delivery of a child, the *Health Plan* pays benefits for the following services provided by a birthing center:

- Pre-natal care;
- Use of the birthing room;
- Services rendered during delivery, including the first 48 hours of follow-up care;
- Care for the newborn and post-partum care of the mother;
- Routine nursery care;
- Services of a *midwife* under the supervision of a medical doctor.

CASE MANAGEMENT

A case management program is included in your Medical Plan in order to provide alternative treatment in the event of a catastrophic or chronic *sickness* or *injury*. This is a voluntary program that monitors your treatment to help determine that you and your eligible dependents are receiving appropriate treatment when medical care is necessary. If you agree to case management, the *Health Plan* may in its discretion decide to pay for certain benefits that would not otherwise be covered under the *Health Plan* if it determines that providing such coverage will save the *Health Plan* from covering other more expensive treatments.

Case management is a process by which a case management coordinator works with the patient, the family and attending *physician* to develop an appropriate treatment plan and to identify and suggest alternatives to traditional inpatient *hospital* care. Examples of the types of cases that are appropriate for this program include severe traumatic *injuries* such as burns, spinal cord *injury*, cancer, cardiovascular disease, stroke and AIDS.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

If an alternative treatment plan is suggested by the case management coordinator, such alternative treatment plan cannot be commenced unless the *Health Plan* as well as you and your *physician* agree to the alternative plan. The purpose of the program is to benefit the patient. If you or your *physician* do not think the alternative treatment is to your benefit, you do not have to participate. Also, before you agree to any treatment plan suggested, you will be told how much the *Health Plan* will pay for the treatment.

All requests for case management must be approved by case management services and the *Health Plan*. For information on case management, please contact the Health Plan Office.

CHIROPRACTIC CARE

Chiropractic care is covered for up to 20 visits per individual per calendar year. The maximum allowable charge for *chiropractic care* is \$50 per visit.

CONTRACEPTION

Various forms of contraception are covered by the *Health Plan*; some under the Medical Plan and some under the Prescription Drug Plan, as follows:

- Depo-Provera, IUDs and Norplant are covered under the Medical Plan or the Prescription Drug Plan. These devices are covered under the Prescription Drug Plan if purchased at a pharmacy. Otherwise they are covered under the Medical Plan.
- Vasectomies are covered under the Medical Plan; and
- Diaphragms and birth control pills are covered under the Prescription Drug Plan.

EMERGENCY ROOM

Emergency room treatment is covered at the same percentages as *hospital* care, except that there is an additional \$50 co-payment in addition to the annual deductible. The \$50 co-payment does not count towards the annual stop-loss or out-of-pocket limit. The \$50 charge will be waived if you are admitted into the *hospital* because of the emergency.

FOOT ORTHOTICS

Custom-molded foot orthotics are covered once every 12 months for children age 16 and under and once every 24 months for participants or dependents over age 16.

HOME HEALTH CARE

Home health care is covered when *medically necessary*. *Home health care* services include intravenous (IV) therapy and home rehabilitation care.

HOSPICE CARE

The *Health Plan* covers *hospice* care for *terminally ill* participants and their eligible dependents. *Hospice* care is an interdisciplinary program of palliative care and supportive services that address the physical, spiritual, social and economic needs of the *terminally ill* patient and their family. The goal of *hospice* care is to keep the patient physically comfortable and free of pain and to assist the patient and family in dealing with the impending death. *Hospice* care also includes bereavement counseling for the immediate family.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

Hospice care can be provided in two types of settings: at home or at an inpatient *hospice* facility. The inpatient facility must be certified by *Medicare* in order to be covered.

For the patient, the following are covered under *hospice* care in addition to what's covered under the Medical Plan for non-*hospice* treatment:

- Room and board at a certified *hospice*, up to the average semi-private room rate;
- *Interdisciplinary team* charges;
- Charges for dietary services and nutritional supplements as prescribed by a *physician*;
- Rental of necessary medical supplies or equipment (hospital bed, wheelchair, oxygen tank, etc.);
- *Medical social services* charges;
- Charges for services provided by a licensed religious counselor, unless the services are provided to a member of the counselor's congregation in the course of duties to which the counselor has been called.

Some *hospice* care benefits are payable for the immediate family of the patient. They are:

- Charges for respite care provided in the home or on an outpatient basis; and
- Bereavement counseling not to exceed a total of six visits for all family members and for no longer than 12 months following the death of the patient.

HOSPITAL

The *Health Plan* provides coverage for the following *hospital* care and services:

- Charges for room, board and general nursing services in a semi-private room. If you stay in a private room, charges that are more than the *hospital's* most common semi-private room rate will not be considered. You are responsible for these excess charges.
- Charges for an *intensive care unit* or similar care unit.
- Charges for routine nursery care.
- Treatment in a *hospital* emergency room.
- *Hospital*-related services.
- Use of operating rooms.

There is an additional \$500 co-payment per admission to a non-*PPO* hospital. The \$500 co-payment does not count towards the annual stop-loss or out-of-pocket limit.

INFERTILITY TREATMENT

Effective January 1, 2003, infertility treatments are no longer covered.

INJECTED/INFUSED DRUGS

Many injected or infused drugs for home use are covered by the Prescription Drug Plan. *Medically necessary* prescription drugs injected or infused at a *physician's* office or in the home are allowed at the Average Wholesale Price (AWP), less a *PPO* discount for an in-network

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

provider. The *Health Plan* pays at the standard 90% for in-network, and 70% (under the DGA Premier Choice Plan) or 60% (under the DGA Choice Plan) for non-network.

MATERNITY CARE

Maternity care benefits are provided for participants and dependent spouses. They are not generally provided for dependent children with maternity needs. However, if an eligible dependent child has *complications of pregnancy*, maternity care is covered and the newborn child shall be covered only for the first 31 days after birth. In compliance with the Newborn and Mothers Health Protection Act, the *Health Plan* allows *hospital* stays of at least 48 hours for normal deliveries and at least 96 hours for cesarean section deliveries. The time periods begin at the birth of the child.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours for cesarean section). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the *Health Plan* or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MEDICAL SUPPLIES

The *Health Plan* provides coverage for the following medical supplies:

- Anesthetic supplies and the cost of their administration. The *Health Plan* takes into account the type of surgery, time in attendance and the geographical area in which the surgery is performed. Charges for anesthesia equipment and supplies are considered as part of the global anesthesia allowance if billed by the anesthesiologist.
- Rental of *durable medical equipment* including wheelchair, *hospital*-type bed and iron lung, up to the purchase price. If the purchase of this equipment would cost less, then that is allowed.
- Artificial limbs, eyes and other prosthetic devices.
- Casts, splints, trusses, crutches, braces and orthotics.
- Oxygen and the rental of equipment for giving oxygen.

Please note that some diabetic supplies may be covered under the Prescription Drug Plan. Please see page 60.

NURSING CARE (In or out of the *hospital*)

The services of a registered nurse, licensed practical nurse, or licensed vocational nurse (not related to you or your dependents by blood or marriage) where they are *medically necessary* are covered. The charges of private duty nurses in a *hospital* are not covered. That is because *hospitals* provide staffs of registered nurses for care during hospitalization, so those charges are included in the *hospital's* room and board charges.

The maximum benefit payable for nursing care is \$25,000 per calendar year. A doctor's prescription for private duty nursing care does not on its own qualify as the reason for coverage of this type of nursing. The final decision as to whether private duty nursing care will be covered by the *Health Plan* will be based solely on the nursing notes and other evidence of the type of

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

care provided. However, you may want to have your attending *physician* contact the Health Plan Office to ascertain whether or not the prescribed nursing care will be covered under the contract.

Custodial care is not covered, except under *hospice care*.

PHYSICIAN CARE (In or out of the *hospital*)

- Home, office and *hospital* visits.
- Services of *physicians*, surgeons and *assistant surgeons*, including specialists. The allowance for a *physician* assistant surgeon will never be more than 20% of the allowance for the procedure. The allowance for assistant surgery services by a *physician's* assistant or other paramedical personnel permitted to assist at surgery under state regulation, will be no more than 10% of the allowance for the procedure. The use of an *assistant surgeon* must be *medically necessary*.

If multiple surgical procedures are performed through the same incision, payment will only be made for the major procedure. If two or more surgical procedures are performed through separate incisions, payment will be made for the major procedure with up to 50% additional payment for all other procedures performed at that time. No additional allowances will be given for those procedures considered incidental or non-covered.

PSYCHIATRIC CARE — INPATIENT

Inpatient psychiatric care is covered, but only if obtained through the Entertainment Industry Referral and Assistance Center (EIRAC) or The Actors' Fund of America. Each organization offers consultation, assessment, evaluation, referral and follow-up to appropriate care.

- EIRAC offers the California entertainment industry a centralized program for individuals with psychiatric problems. The program is staffed by full-time professionals who are thoroughly trained in crisis intervention and employee assistance problems.
- The Actors' Fund of America is the oldest organization servicing the entertainment industry, helping professionals nationwide for over 100 years. The Actors' Fund is staffed by professional social workers and other mental health practitioners.

No benefits will be payable for inpatient psychiatric care unless you first contact EIRAC or The Actors' Fund.

The Medical Plan

Those participants requiring inpatient psychiatric care must first contact either:

EIRAC

(for California residents)

(818) 981-6789

or

The Actors' Fund of America

(for all except California residents)

(800) 221-7303 or (212) 221-7301

Both EIRAC and The Actors' Fund are staffed to take your call 24 hours a day, 7 days a week. Except for emergencies, pre-approval of care/treatment must be obtained prior to treatment. In an emergency situation, you are allowed a 48-hour grace period in which to call for arrangements of care.

Benefits

These benefits are not subject to the *Health Plan* deductible. If inpatient treatment is authorized by EIRAC or The Actors' Fund, benefits are paid as follows:

- 90% of *covered expenses* for an initial hospitalization*;
- 80% of *covered expenses* for a second hospitalization*;
- 70% of *covered expenses* for a third hospitalization*;
- 50% of *covered expenses* for a fourth hospitalization*; and
- 50% of *covered expenses* for a fifth and later hospitalization*.

* Each treatment is limited to 45 days. The fifth and later treatments are limited to a combined total of 90 days.

Inpatient hospitalization can often be converted to less costly and more accommodating modes of treatment. When possible, other types of treatment may be recommended by EIRAC or The Actors' Fund, such as partial hospitalization, residential treatment and structured/intensive outpatient treatment. Expenses of *hospitals* and freestanding facilities to which you are referred by either EIRAC or The Actors' Fund are covered by this benefit.

Partial hospitalization and residential treatment will be reimbursed on the same basis as benefits for inpatient treatment. Structured/intensive outpatient treatment will be reimbursed at 80% of *covered expenses*.

PSYCHIATRIC CARE — OUTPATIENT

Benefits are paid at 50% of the *reasonable and customary charge*, up to a maximum of 20 visits per calendar year. No referral or preauthorization is needed for this benefit. Unlike inpatient care, this benefit is subject to the calendar year deductible. Please see "What's Not Covered Under the Medical Plan" on page 54 for psychiatric treatment that is not covered.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

SUBSTANCE ABUSE PROGRAMS — INPATIENT

Substance abuse care (alcoholism and drug dependency) is covered, but only if obtained through EIRAC or The Actors' Fund of America. Each organization offers consultation, assessment, evaluation, referral and follow-up to appropriate care.

- EIRAC offers the California entertainment industry a centralized program for individuals with substance abuse problems. The program is staffed by full-time professionals who are thoroughly trained in alcohol and drug dependency.
- The Actors' Fund of America is the oldest organization servicing the entertainment industry, helping professionals nationwide for over 100 years. The Actors' Fund is staffed by professional social workers and other practitioners.

No benefits will be payable for treatment of substance abuse unless you first contact EIRAC or The Actors' Fund.

Those participants requiring treatment for substance abuse must first contact either:

EIRAC

(for California residents)

(818) 981-6789

or

The Actors' Fund of America

(for all except California residents)

(800) 221-7303 or (212) 221-7301

Both EIRAC and The Actors' Fund are staffed to take your call 24 hours a day, seven days a week. Except for emergencies, pre-approval of care/treatment must be obtained prior to treatment. In an emergency situation, you are allowed a 48-hour grace period after seeking care in which to call for arrangements of care.

Benefits

These benefits are not subject to the *Health Plan* deductible. If treatment is authorized by EIRAC or The Actors' Fund, benefits are paid as follows:

- 90% of *covered expenses* for an initial hospitalization*;
- 75% of *covered expenses* for a second hospitalization*; and
- 60% of *covered expenses* for a third hospitalization*.

*Each treatment is limited to 45 days.

Inpatient hospitalization can often be converted to less costly and more accommodating modes of treatment. When possible, other types of treatment may be recommended by EIRAC or The Actors' Fund, such as partial hospitalization, residential treatment and structured/intensive outpatient treatment. Expenses of *hospitals* and freestanding facilities to which you are referred by either EIRAC or The Actors' Fund are covered by this benefit.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

Partial hospitalization and residential treatment will be reimbursed on the same basis as benefits for inpatient treatment. Structured/intensive outpatient treatment will be reimbursed at 80% of *covered expenses*.

Benefits for substance abuse care are limited to a lifetime maximum payment of \$30,000 per individual. The lifetime substance abuse maximum is \$30,000 whether or not there has been an interruption in coverage.

THERAPY BENEFIT (In or out of *hospital*, when prescribed by a *physician*)

Therapy includes:

- *physical therapy* administered by a Registered Physical Therapist (RPT)
- speech therapy;
- *biofeedback*;
- *vision therapy* (excluding refractions);
- osteopathic adjustments or manipulations by a Doctor of Osteopathy (DO)
- *occupational therapy* (OT); and
- monitored cardiac rehabilitation.

Care and treatment performed by an MD or a licensed, certified *physician* or general practitioner is covered up to a maximum number of visits per calendar year for any combination of therapies. There is an annual calendar year maximum of 50 visits per individual. The maximum *allowable charge* is \$85 per visit for all of the above therapies. Multiple treatments in one day by the same provider are treated as one visit and are thus subject to the per visit maximum of \$85. Please refer to the Glossary for the definitions of some of these types of therapy services.

It is recommended that before undergoing any type of therapy you check with the Health Plan Office to determine if the therapy and the provider are covered under the *Health Plan*.

Speech therapy is covered when prescribed by a *physician* as a result of:

- surgery, accidental *injury*, stroke, radiation laryngitis, swallowing disorders, tongue thrusting, cerebral palsy, or other similar structural or neurological diseases;
- congenital anomalies which have been surgically corrected; or
- a speech impairment in a child who has failed to acquire comprehensible speech articulation as a documented result of hearing loss, Down's Syndrome, cerebral palsy or other documented neurological disease.

Speech therapy expenses are not covered for behavioral or learning disorders such as stuttering, lispings or slow speech development.

Speech therapy and *occupational therapy* expenses will not be covered when part of an educational therapy for a child with a learning delay or when *necessary treatment* is provided or reimbursed by a school system or other governmental agency.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

WELL CHILD CARE

Well child care is covered for children under age 17. This includes physical exams, diagnostic procedures and immunizations given as standard medical practice.

WELLNESS BENEFIT

The *Health Plan* pays to help you stay well and prevent disease. Each family is allowed \$1,500 of *wellness benefits* per calendar year. The following are allowable under the wellness program:

- Routine physical examinations for individuals age 17 and over;
- Smoking cessation programs (certification of completion required);
- Weight-loss programs, not including food, and weight-loss prescription drugs, if the program and drugs are treatment for a specific disease diagnosed by a *physician*;
- Flu shots, vaccinations and immunizations for individuals age 17 and over;
- Well woman care;
- Prostate Specific Antigen (PSA);
- Hearing aids, batteries not included; and
- Nutritional counseling.

The *Health Plan* will reimburse the participant directly or will accept assignment. All you need to do is submit your bills as you have in the past, including a statement requesting coverage for the charge under the *wellness benefit*. The Health Plan Office will determine under which portion of the contract the bill should be processed.

To be considered, the services must be performed by a licensed practitioner. To determine whether a service or treatment is covered, it is recommended that you contact the Health Plan Office before the expense is incurred.

The following are not covered under the wellness benefit:

- Vitamins;
- Food supplements;
- Holistic treatments;
- Personal trainers;
- Health club memberships;
- Athletic wear; or
- Athletic equipment.

The Medical Plan

WOMAN CARE

The *Health Plan* covers:

1. Routine pap smear.
2. Routine mammographic examinations in accordance with the following schedule:
 - one mammogram for covered females age 35 through 39;
 - for covered females age 40 through 49, a mammogram every other calendar year unless recommended more frequently by her attending *physician*; an
 - for covered females age 50 and over, a mammogram each calendar year.
3. 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.

X-RAYS (in or out of the *hospital*)

The *Health Plan* covers *medically necessary* diagnostic x-ray and testing services such as MRIs and CAT scans.

▶ WHAT'S NOT COVERED UNDER THE MEDICAL PLAN

No medical benefits are payable for:

1. Treatment that is not *medically necessary*.
2. Charges in excess of *reasonable and customary charges*.
3. Expenses incurred that are not due to *sickness* or *bodily injury*.
4. Any acts attributable to declared or undeclared war.
5. Federal government agency care, except charitable research *hospitals* or when the law mandates.
6. Conditions arising out of or in the course of employment or compensable under any Workers' Compensation or Occupational Disease Act or other similar laws.
7. Services received from a health care provider who is related to you or your dependent, or living with the person requiring treatment.
8. Treatment or procedures that are *Experimental* or *investigational*.
9. *Complementary and alternative medicine*, including but not limited to homeopathic, naturopathic and holistic medicine.
10. *Hospital* confinement or service which is not approved by a *physician*.
11. Hospitalization primarily for diagnostic studies.
12. Fees for a surgical suite unless the facility is state licensed and/or Medicare-approved as an *ambulatory surgical center*.
13. Care in convalescent homes, nursing or rest homes or institutions of a similar nature.
14. Inpatient private duty nursing.
15. Dental care, including hospitalization, anesthesia, MRI/CAT scans related to dental care. Some dental care is covered under the Dental Plan.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

16. Glasses and eye examinations for the purpose of prescribing glasses. These may be covered under the Vision Plan.
17. Contact lenses, except contact lenses when required because of surgery. Contact lenses may be covered under the Vision Plan.
18. Any surgical procedure, such as LASIK, to correct a refractive error.
19. Prescription drugs, except as specifically covered under the Medical Plan. (Please see the Prescription Drug section for information about covered drugs.)
20. Services and supplies for which the patient legally is not required to pay.
21. Expenses written off by the provider or not charged to the patient.
22. Charges for after-hours care.
23. Charges for completing claim forms, reports, etc. and for copying medical file records.
24. Charges for mailing and shipping of medical supplies.
25. Sales or other taxes on services, products and equipment.
26. Claims submitted after one year following the date of service, except in cases of retroactive eligibility granted through late contributions.
27. Telephone or Internet consultations and testing.
28. Charges for *sickness* or *injury* occurring from the commission of an illegal act.
29. Intentionally self-inflicted *injuries* or *sicknesses* unless due to medical condition.
30. Rest cures or *custodial care*.
31. Infertility treatment.
32. Reversal of vasectomies or tubal ligation.
33. Autologous blood storage and umbilical cord blood storage charges.
34. *Cosmetic surgery* and prescription drugs prescribed for cosmetic purposes (including collagen injections), except conditions resulting from a functional disorder or from an accidental *injury*.
35. Laser resurfacing, including treatment for rosecea.
36. Routine foot care, including corrective shoes or inserts and cutting, trimming or partial removal of toenails, except for prevention of diabetic complications, treatment of corns and calluses.
37. Normal delivery of a participant's dependent child's children, except for *complications of pregnancy*.
38. Prepared childbirth classes, including Lamaze and doulas.
39. Fees for a masseur, masseuse, massage therapist (M.T.), dance therapist or art therapist.
40. Educational therapy, play therapy, academic evaluations, and treatment of learning disabilities.
41. Fees for health club or gymnasium memberships.
42. Marriage counseling.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Medical Plan

43. Substance abuse treatment except as specifically provided by EIRAC or The Actors' Fund.
44. Transportation, except local ambulance service or as provided on page 45.
45. Hydrocolators, whirlpool baths, sunlamps, heating pads, exercise devices and similar general use/convenience items.
46. Supports or devices used primarily for safety or performance in sports-related activities.
47. Incontinence supplies.
48. Over-the-counter supplies for home care, such as bandages, cotton swabs, cotton balls, alcohol pads, gauze pads or similar products.
49. Replacement batteries for *durable medical equipment*.
50. Air conditioners, humidifiers, allergy-free pillows, mattress covers and similar environmental control equipment.
51. Parallel bars, *biofeedback* equipment or similar institutional equipment that is appropriate for use in a medical facility and is not appropriate for use in the home.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Prescription Drug Plan

- Prescription drugs and the Express Scripts drug program
- Buying prescription drugs at a non-participating pharmacy
- Coordination of benefits
- What's not covered under the Prescription Drug Plan

The Prescription Drug Plan

The *Health Plan* covers drugs and medicines that require the written prescription of a *physician* and that are dispensed by an Express Scripts network pharmacist. Over-the-counter drugs and medicines are not covered by the *Health Plan*.

PRESCRIPTION DRUGS AND THE EXPRESS SCRIPTS DRUG PROGRAM

There is no deductible associated with prescription drugs, and prescription drugs do not count towards the stop-loss or out-of-pocket limit (see page 38 for details on the stop-loss and out-of-pocket limit). However, prescription drugs do count towards the \$2,000,000 lifetime maximum described on page 40.

RETAIL BENEFITS

There are more than 50,000 Express Scripts walk-in pharmacies across the United States, representing more than 98% of all retail pharmacies. In addition, the five TIHN pharmacies are also part of the Express Scripts program (see page 35 for addresses and hours). To find a participating Express Scripts pharmacy, call Express Scripts directly at (800) 789-6443. You may request, at no charge, a list of Express Scripts pharmacies from the Health Plan Office. You may purchase up to a 30-day supply at a time; if you need a larger supply you should use the mail order program.

To use an Express Scripts pharmacy, follow these simple procedures:

- Present your Express Scripts ID card to a participating pharmacist.
- Pay the applicable co-payment amount.

For a 30-day supply of medication you pay the following co-payments:

Generic	\$10
Brand Name	\$24
Specialty	Covered at 50% with \$40 minimum co-payment

Currently, Viagra® and non-sedating antihistamines are covered as specialty drugs.

A generic drug uses its chemical name, while the brand name is the trade name under which the drug is advertised and sold. A generic drug costs you and the *Health Plan* less than the brand name medication. By law, generic drugs must contain the same active ingredients and be equivalent in strength and dosage form to the brand name product.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Prescription Drug Plan

The co-payment is your responsibility; do not send your receipts to the Health Plan Office for reimbursement. There are no claim forms to complete or receipts to mail to the Health Plan Office.

Note: If you request a brand name drug when a generic alternative is available, and your doctor has not specified “dispense as written” on the prescription, you will be responsible for the cost of the brand name drug in excess of the cost of the generic alternative, plus the co-payment.

Be sure you show your Express Scripts ID card or identify yourself as an Express Scripts participant to receive the appropriate discount. Prescriptions purchased without your ID card or at a non-Express Scripts pharmacy may cost you more.

MAIL ORDER PRESCRIPTION PROGRAM

For an even greater savings, maintenance medications should be purchased through the Express Scripts mail order program.

For a 90-day supply of medication you pay the following co-payments:

Generic	\$25
Brand Name	\$60
Specialty	Covered at 50% with \$60 minimum co-payment

As part of this program, any brand name drug with a generic equivalent will be dispensed in the generic form. If your doctor wants you to have the brand name drug, it must be written on the prescription. Mail order refills may be obtained by calling Express Scripts at (800) 789-6443 or mailing the refill form sent with your medication.

	GENERIC	BRAND NAME	SPECIALTY
At an Express Scripts participating pharmacy — up to 30-day supply	\$10	\$24	\$40*
Through the mail order program — up to 90-day supply	\$25	\$60	\$60*

*For specialty drugs, the *Health Plan* pays benefits at 50% with a minimum co-payment (\$40 for retail and \$60 for mail order). That is, the participant pays the greater of the minimum co-payment or 50% of the cost of the drug. Currently, Viagra® and non-sedating antihistamines are covered as specialty drugs.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Prescription Drug Plan

DIABETIC SUPPLIES

The following diabetic supplies are covered under the Prescription Drug Plan:

- lancets;
- diabetic testing reagents (test strips);
- alcohol wipes or swabs; and
- single-use insulin syringes.

Re-usable syringes are not covered. In addition, some glucometers are covered. Please contact Express Scripts at (800) 789-6443 to confirm which glucometers are covered.

BUYING PRESCRIPTION DRUGS AT A NON-PARTICIPATING PHARMACY

You may purchase your prescription drugs at a non-Express Scripts participating pharmacy. However, you will not receive the Express Scripts discount, you will have to pay the full amount at the time of purchase, and you will have to file a claim form with Express Scripts for your partial reimbursement. To file a claim, request a claim form from Express Scripts and submit the necessary information and receipts. They will reimburse you for the amount they would have covered at the discounted rate, less the applicable co-payment amount.

COORDINATION OF BENEFITS

The Prescription Drug Plan has coordination of benefits rules similar to the Medical Plan. For an explanation of coordination of benefits, please see page 40.

Call Express Scripts at (800) 789-6443 for mail order prescriptions or to find a participating pharmacy.

WHAT'S NOT COVERED UNDER THE PRESCRIPTION DRUG PLAN

1. Over-the-counter drugs or vitamins, even if prescribed or recommended by a *physician*;
2. Prescription drugs not approved by the Food and Drug Administration for the treatment rendered;
3. Prescription drugs due to non-covered procedures; and
4. Viagra®, without prior authorization or in excess of 10 pills each 30 days.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Dental Plan

- The Delta Dental DeltaPreferred option
- Using an out-of-network dentist
- Dental benefits at a glance
- Preauthorization of benefits
- What's covered under the Dental Plan
- What's not covered under the Dental Plan
- Dental coverage extensions

The Dental Plan

Generally, the Dental Plan portion of the *Health Plan* describes the covered dental benefits. However, if you reside in California, you may be able to elect a dental maintenance organization (DMO) option in lieu of the Dental Plan. If applicable, you must choose between the Dental Plan and the DMO option during your *open enrollment period*. This election is then effective for your benefit period and may not be changed until your next *open enrollment period*. For a description of the benefits provided under the DMO option, refer to the DMO Summary of Benefits and Evidence of Coverage, which are available upon request from the Health Plan Office and are incorporated here by reference.

Questions regarding dental coverage should be directed to Delta Dental of California.

You can reach them at:

Delta Dental Plan of California

P.O. Box 7736

San Francisco, California 94120

(888) 335-8227

www.deltadentalca.org

THE DELTA DENTAL DELTAPREFERRED OPTION

The DeltaPreferred Option (DPO) works similarly to the PPO in the Medical Plan. Each time you visit a dentist you have the option of using an “in-network” (DPO) dentist or using a “out-of-network” (non-DPO) dentist. When you use a DPO dentist, you will receive higher benefits than you would receive when going to a non-DPO dentist. There are several ways that you save money when using an in-network dentist:

- There is no deductible when using a DPO dentist;
- All procedures, except orthodontia, are paid at a higher percentage; and
- DPO dentists have agreed to charge discounted fees.

You’ll see the greatest savings when you visit a Delta Dental dentist who participates in Delta Dental’s DPO program. These dentists have agreed to charge discounted fees to our participants. In addition, there is no deductible, and the co-payment percentage you’ll pay is lower for most dental services. What this means is not only is there no deductible, but with the discounted fees and the lower co-payment percentages (e.g., under Category II you pay only 20% for DPO treatment versus 40% for non-DPO), you pay a smaller percentage of a smaller amount. Also, DPO dentists will take care of all paperwork, and agree to charge only the patient share (co-payment) at the time of treatment.

Delta Dental’s PPO is called the DeltaPreferred Option (DPO). Remember that using a DPO or “in-network” dentist (not simply a Delta dentist) will give you the greatest savings.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

How Can I Find Out If My Dentist Participates in the DPO?

There are several ways:

- You can ask your dentist directly—be sure to ask if your dentist participates in Delta Dental's *DPO*.
- You can visit the Delta Dental website at www.deltadentalca.org, and click the Dentist Directory button.
- You can call Delta Dental at (800) 4-AREA-DR (800-427-3237).
- Ask the Health Plan Office for a free provider directory.

Your current dentist may already be affiliated with Delta Dental. In fact, 92% of dentists currently practicing in California are Delta Dental dentists.

WHAT THE PLAN PAYS

The *Health Plan* pays a percentage of *DPO* charges based upon one of four categories of service. The *Health Plan* pays 100% for Category I procedures, 80% for Category II procedures, 70% for Category III procedures and 50% for orthodontia for dependent children under 19.

USING AN OUT-OF-NETWORK DENTIST

Under this Dental Plan, you are not limited to in-network dentists. Out-of-network dentists include many dentists who participate with Delta Dental, but aren't *DPO* dentists, and other dentists who do not participate with Delta Dental at all.

If you go to a dentist who participates with Delta Dental but isn't a *DPO* dentist, all paperwork will be taken care of by the Delta Dental dentist for you. Remember that there are deductibles and co-payments for services as described below.

If you decide to go to a dentist who doesn't participate with Delta Dental at all (a "non-Delta" dentist), you will be responsible for any difference between the *reasonable and customary charges* and the amount your dentist charges. Also, you may need to submit a claim form to receive this reimbursement.

For information on how to file a dental claim, please refer to page 79.

The Dental Plan

HOW THE DEDUCTIBLE WORKS

Dental benefits are payable once you satisfy the calendar year deductible. The Dental Plan deductible is separate from the Medical Plan deductible. Before benefits are payable to you, you must satisfy the calendar year deductible which is \$50 for an individual and \$100 for a family. Like the Medical Plan, the family deductible is “cumulative” and is considered satisfied once two or more family participants have together met the annual \$100 deductible. When this occurs, the deductible amounts applied toward other family participants will be adjusted.

If you have individual coverage, the dental deductible is \$50 per calendar year. Once you have \$50 in covered expenses, the *Health Plan* will pay benefits on *covered expenses* above that amount.

When you have family coverage, if two or more covered family participants have met the combined deductible amount of \$100 in one calendar year, no further deductibles will be charged to the family for that year.

As with the Medical Plan, there is also a special deductible “carry-over” provision that applies to everyone enrolled in the Dental Plan. If you have dental expenses in the last quarter of the calendar year (October, November and December) that apply toward meeting your deductible, those dental expenses will be “carried over” and applied to next year’s deductible. For example, if you have eligible expenses of \$30 in December which apply toward your deductible, you will only need another \$20 after January 1 to satisfy the deductible for the new year.

WHAT THE PLAN PAYS

Once you satisfy the deductible, the *Health Plan* pays a percentage of *reasonable and customary charges* based upon one of four categories of service. The *Health Plan* pays 85% for Category I procedures, 60% for Category II procedures, 50% for Category III procedures and 50% for orthodontia for dependent children under 19. You are responsible for the remaining percentage of charges and any amounts above *reasonable and customary charges*.

The maximum amount payable for covered dental expenses during a calendar year is \$2,500 per individual. Orthodontia is limited to a lifetime maximum of \$1,500 per dependent child under 19.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

DENTAL BENEFITS AT A GLANCE

CATEGORY I	CATEGORY II	CATEGORY III	ORTHODONTIA FOR DEPENDENT CHILDREN TO AGE 19
Oral exams	Fillings	Endodontics	Non-cosmetic straightening
X-rays	Crowns	Periodontics	
Cleaning (prophylaxis)	Cast restorations	Prosthodontics	
Consultations		Oral surgery bridges	
Fluoride treatments (under age 14)		Implants (non-cosmetic)	
Sealants (under age 14)			
Space maintainers (under age 19)			
Night guards			
\$2,500 calendar year maximum per individual			\$1,500 lifetime maximum
USING AN IN-NETWORK (DPO) DENTIST			
No calendar year deductible			
Plan pays 100%	Plan pays 80%	Plan pays 70%	Plan pays 50%
You pay 0%	You pay 20%	You pay 30%	You pay 50%
Charges will not exceed reasonable and customary			
USING AN OUT-OF-NETWORK (NON-DPO) DENTIST			
You pay \$50 (\$100 family) calendar year deductible			
Plan pays 85%	Plan pays 60%	Plan pays 50%	Plan pays 50%
You pay 15%	You pay 40%	You pay 50%	You pay 50%
You pay charges above reasonable and customary			

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

PREAUTHORIZATION OF BENEFITS

Preauthorization is recommended, but not required, for all dental treatment that is expected to cost \$300 or more. Your dentist is fully acquainted with the procedure of requesting preauthorization. If you go ahead with treatment without having the treatment preauthorized, the *Health Plan* will pay benefits only for the charges that would have qualified in a preauthorization review. Therefore, you will be responsible for the difference in cost. Call Delta Dental for details on how to obtain preauthorization.

WHAT'S COVERED UNDER THE DENTAL PLAN

The following expenses are *covered expenses*. Services not listed will not be considered *covered expenses*. An expense will be deemed incurred as of the date the service is provided or the supply is furnished. For a procedure that involves several visits to the dentist, the date of service is the first dental visit.

Please refer to the Claims section of this booklet for instructions on filing a dental claim (page 79).

Category I (Pays at 100% in-network, 85% out-of-network)

- Oral examinations, but not more than one in any period of 150 consecutive days.
- Prophylaxis (cleaning of teeth) and scaling, but not more than three times per calendar year.
- Fluoride treatments, but only for covered individuals under age 14.
- Space maintainers, but only for covered individuals under age 19.
- Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment. Also other dental x-rays, but not more than one full mouth or panoramic x-ray or series in any period of 36 consecutive months and not more than one set of supplementary bite-wing x-rays in any period of 150 consecutive days.
- Night guards.
- Sealants, but only for covered individuals under age 14.
- Charges for emergency relief of dental pain on a day for which no other dental service, other than x-rays, is performed.

Category II (Pays at 80% in-network, 60% out-of-network)

- Fillings (amalgam or gold).
- Inlays, gold fillings, or crowns (including precision attachments for dentures).
- Repair or re-cementing crowns or inlays.
- Cast restorations.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Category III (Pays at 70% in-network, 50% out-of-network)

- Extractions.
- Implants, non-cosmetic only.
- Oral surgery, including surgical extraction.
- General anesthetics when *medically necessary* and administered in connection with oral surgery or other covered dental services.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- Endodontic treatment, including root canal therapy.
- Injection of antibiotic drugs.
- Repair or re-cementing bridgework or dentures.
- Relining of dentures.
- Initial installation of partial or full removable dentures (including adjustments for the six month period following installation).
- Initial installation of fixed bridgework and pontics, including inlays and crowns as abutments.
- Subject to the Prosthesis Replacement Rule, replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or the addition of teeth to a partial denture.
- Replacement of an existing partial denture or fixed bridgework by new bridge-work, or the addition of teeth to existing fixed bridgework, subject to the Prosthesis Replacement Rule.
- Treatment for Temporomandibular Joint Dysfunction (TMJ) if procedures are dental in nature. Please contact Delta Dental for assistance. Medical treatment of TMJ may be covered under the Medical Plan.

Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacement or additions to existing dentures or bridge-work will be covered only if satisfactory evidence is furnished that at least one of the following applies:

- the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;
- the existing denture or bridgework cannot be made serviceable and was installed at least three years prior to its replacement; or
- the existing denture is an immediate temporary denture which cannot be made permanent. Replacement by permanent denture is required to replace the temporary denture.

Special Provisions for Orthodontic Treatments

A separate benefit for orthodontic treatment is provided only for your dependent children under age 19.

Benefits are paid at 50% of *reasonable and customary charges* and are paid on a prorated basis throughout the course of treatment. *Covered expenses* are not subject to the dental deductible, and any benefits paid for orthodontic treatment will not count against your dependent child's calendar year maximum.

The lifetime maximum for all orthodontic treatment is \$1,500 per dependent child whether or not there has been an interruption in dental coverage.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

▶ WHAT'S NOT COVERED UNDER THE DENTAL PLAN

No dental benefits are payable for:

1. Dental services or supplies that are not *medically necessary*.
2. Any expenses covered under the Medical Plan.
3. Services received from a relative of you or your spouse or dependent.
4. Conditions arising out of or in the course of employment or compensable under any Workers' Compensation or Occupational Disease Act or other similar laws.
5. *Experimental* procedures or treatments.
6. Sealants for patients age 14 and older, bonding, acid etching, veneers, bleaching and any services for cosmetic purposes, except for conditions resulting from an accidental *injury*. Facing on crowns or pontics posterior to the second bicuspid will always be considered cosmetic.
7. Study models.
8. Any services furnished for dental care of a congenital or developmental malformation except as specifically provided for orthodontic treatment.
9. Any orthodontic services or supplies, except as specifically provided for in this booklet.
10. Appliances (bite plates, occlusal splints, etc.), restorations or procedures for the purpose of altering vertical dimension or restoring or maintaining occlusion, except in connection with periodontal surgery.
11. Appliances, restorations or procedures for the purpose of splinting or replacing tooth structure lost as a result of abrasion or attrition.
12. Replacement of lost, broken or stolen appliances.
13. Any services not furnished by a dentist, except:
 - those performed by a licensed dental hygienist under a dentist's supervision; and
 - x-rays ordered by a dentist.
14. Emergency dental treatment on the same day other dental services are performed.
15. Training or supplies used for dietary counseling, oral hygiene or plaque control.
16. *Hospital* stays for or in connection with dental services.
17. Any acts attributable to declared or undeclared war.
18. Intentionally self-inflicted *injuries* or *sicknesses* unless due to a medical condition.
19. Prescription drugs.
20. Anesthesia, except for general anesthesia for oral surgery.
21. Charges for *sickness* or *injury* occurring from the commission of an illegal act.

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■ DENTAL COVERAGE EXTENSIONS

If you lose your coverage under the *Health Plan*, your dental benefits are extended as follows (additional charges are subject to the prior period's limits on the maximum benefits):

- if the master impression was taken for an appliance or modification of an appliance while the coverage was in force, benefits will be payable if the appliance is installed within 30 days following loss of coverage;
- if the tooth or teeth were prepared for a crown, bridge, inlay or onlay restoration while the coverage was in force, benefits will be paid if the crown, bridge or cast restoration is installed within 30 days after loss of coverage;
- if the pulp chamber was opened for root canal therapy while the coverage was in force, benefits will be paid if the root canal therapy is completed within 30 days following loss of coverage; or
- if the implant procedure was begun while the coverage was in force, benefits related to the implants will be paid for the first 30 days following loss of coverage.

Vision Plan

- Who provides services
- What's covered under the Vision Plan
- What's not covered under the Vision Plan

The Vision Plan

Vision benefits, provided through Vision Service Plan (VSP) are designed to provide benefits for regular eye examinations and vision care, including glasses or contact lenses. VSP has an extensive nationwide network of doctors who provide quality eye care and materials.

WHO PROVIDES SERVICES

You have the option of receiving services either through a VSP-participating doctor or another eye care provider of your choice. However, if you use a non-VSP participating doctor you will not be able to take advantage of VSP's negotiated rates and discounts.

Under the Vision Plan, there is a \$30 co-payment for the eye exam and a separate \$30 co-payment for covered prescribed lenses and frames.

	CO-PAYMENT
Exam	\$30
Lenses and frames	\$30

WHAT'S COVERED UNDER THE VISION PLAN

The Vision Plan is designed to encourage you to maintain your vision. The *Health Plan* provides the following vision care:

- Vision exams once every calendar year;
- Spectacle lenses or contact lenses once every calendar year; and
- Frames once every other calendar year.

Vision benefits are designed to provide each participant and eligible dependent with an eye examination and corrective lenses. The Vision Plan is not designed to cover medical expenses relating to a vision or eye problem. For example, eye surgery for a detached retina is considered a medical expense and may be covered under the Health Plan.

SPECTACLE LENSES AND FRAMES

VSP covers a wide selection of frames, but not all frames will be covered in full. Please see "Other Expenses for Which You Are Responsible" on page 75 for details. Any costs for lenses and frames exceeding the Vision Plan's allowance are the patient's responsibility. However, when a patient selects a frame that exceeds the Vision Plan's allowance, the additional charges are administered at VSP's controlled costs. Costs for cosmetic options on the lenses and frames are also the patient's responsibility. However, VSP also has controlled

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costs for cosmetic options, and these charges are typically less than usual and customary fees. You should consult your VSP-participating doctor about lens options that may be cosmetic in nature or exceed the VSP allowance. Again, you do not have to use a VSP-participating doctor, but it may save you money when purchasing designer frames or cosmetic options.

CONTACT LENSES

If contact lenses are *medically necessary*, they are covered in full with a VSP-participating doctor. The participating doctor must secure prior approval from VSP for *medically necessary* contact lenses. Contact lenses are considered *medically necessary* if they are for the following conditions:

- following cataract surgery;
- for extreme vision problems that cannot be corrected with spectacle lenses;
- for certain conditions of anisometropia; or
- for certain conditions of keratoconus.

Elective contact lenses are covered in lieu of spectacle lenses. VSP has an allowance for the contact lens evaluation examination, fitting costs and materials. Any costs exceeding that allowance are the patient's responsibility. You may receive new contact lenses with the same frequency as spectacle lenses (once every calendar year). Remember, contact lenses are in lieu of spectacle lenses, so you may not get contact lenses in addition to a pair of spectacle lenses in a calendar year. Nevertheless, you are still eligible for eyeglass frames once every other calendar year.

HOW THE PLAN WORKS WHEN USING A VSP-PARTICIPATING DOCTOR

To access your vision care benefits, simply contact a VSP-participating doctor and make an appointment. If you need help locating a VSP-participating doctor, call VSP at (800) 877-7195 or visit VSP's website at www.vsp.com. You may also request, at no charge, a list of VSP providers from the Health Plan Office.

When making an appointment, identify yourself as a VSP patient. Indicate that you are covered under the Directors Guild of America-Producer Health Plan and provide your VSP identification number (the ID number is the participant's Social Security Number). The VSP participating doctor will then obtain the necessary authorization and information about your eligibility and coverage.

At your appointment, the VSP participating doctor will provide an eye examination and determine if eyewear is necessary. If so, the doctor will coordinate the prescription with a VSP-approved contract laboratory. The doctor will itemize any *non-covered charges* and have you sign a form to document that you received services. VSP will pay the participating doctor directly for the covered services and materials. You are responsible for paying the doctor a \$30 co-payment for the eye examination and a \$30 co-payment for lenses and/or frames. You are also responsible for any additional cost resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a participating doctor from VSP's network assures direct payment to the doctor.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Vision Plan

HOW THE PLAN WORKS WHEN USING A NON-VSP PARTICIPATING DOCTOR
When you use a non-VSP participating doctor or provider, you pay the provider for the full cost of services and then submit a claim for reimbursement. You will be reimbursed for covered services according to the VSP schedule of payments, which may or may not cover the costs of a non-VSP participating provider. The co-payments listed on page 72 are also taken into account for reimbursement purposes when a non-VSP participating provider is used.

Follow the following steps when you obtain services from a non-VSP participating provider:

1. Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type and frame.
2. Send a copy of the itemized bill(s) to VSP. The following information must be included in your documentation:
 - Participant's name and mailing address;
 - Participant's identification number (Social Security Number); and
 - Patient's name, relationship to the participant and date of birth.

You may submit the information on a HCFA-1500 form or any generic insurance claim form that may be available from your non-participating provider.

VSP will reimburse you in accordance with the schedule below; these reimbursement benefits are not assignable. There is no assurance that this schedule will be sufficient to pay for the eye examination or the materials.

SCHEDULE FOR NON-VSP PARTICIPATING DOCTOR CHARGES (After co-payments listed on page 72)	
PROFESSIONAL FEES	
Vision Examination, up to	\$40
MATERIALS	
Single Vision Lenses, up to	\$40
Bifocal Lenses, up to	\$60
Trifocal Lenses, up to	\$80
Frame, up to	\$45
CONTACT LENSES	
Medically Necessary, up to	\$210
Elective, up to	\$105

*If only one lens is required, the benefit is half the amount shown here.

The availability of services under this reimbursement schedule is subject to the same time limits as those described on page 72. Services obtained from a non-participating provider are in lieu of services from a participating doctor of VSP.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

The Vision Plan

If this schedule provides more than your optometrist, ophthalmologist or dispensing optician charges, you will be reimbursed the actual charge. If your service provider charges more than this schedule provides, you will have to pay the difference.

To receive reimbursement for services you receive from a non-VSP participating doctor, you must submit a claim within six months after services are provided. Benefits cannot be assigned to the provider of service.

You must submit the itemized bill(s) and form directly to:

**Vision Service Plan
P.O. Box 997105
Sacramento, California 95899-7105**

OTHER EXPENSES FOR WHICH YOU ARE RESPONSIBLE

VSP is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, there will be an extra charge:

- blended lenses;
- contact lenses (except as noted on page 73);
- a frame that costs more than the Vision Plan allowance;
- cosmetic lenses;
- progressive multi-focal lenses;
- photochromic or tinted lenses other than Pink 1 or 2;
- coated or laminated lenses;
- optional cosmetic processes;
- oversized or undersized lenses;
- UV-protected lenses; or
- certain limitations on low vision care.

WHAT'S NOT COVERED UNDER THE VISION PLAN

There is no benefit for professional services or materials connected with:

1. Orthoptics or *vision therapy* and any associated supplemental testing.
2. Plano lenses (non-prescription).
3. Two pairs of glasses in lieu of bifocals.
4. Lenses and frames furnished under this program which are lost or broken.
5. Medical or surgical treatment of the eyes. (This may be covered under the Medical Plan.)
6. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.
7. Corrective vision services, treatments and materials of an *experimental* nature.
8. Any surgical procedure.

Please Note!

Lenses and frames furnished under this plan which are lost, stolen or broken will not be replaced by the plan except at normal intervals when services are otherwise available.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

General Provisions

- Claims
- Claims and appeals procedures
- Recovery incentive program
- Third party reimbursement
- ERISA required information
- Women's Health and Cancer Rights Act of 1998
- A final word

General Provisions

This section contains the *Health Plan's* general provisions, including the recovery incentive program, third party reimbursement and administrative details. It also contains a statement of your rights as a *Health Plan* participant.

CLAIMS

FILING A MEDICAL CLAIM

All completed medical and *hospital* claims should be sent directly to the Health Plan Office at:

Directors Guild of America–Producer Health Plan
8436 West Third Street, Suite 900
Los Angeles, California 90048-4189
(323) 866-2200
Toll Free Outside Los Angeles area (877) 866-2200
Fax: (323) 782-9287

Claims should be submitted to the *Health Plan* in a timely manner after your first visit to a non-PPO doctor. Be sure to explain this to your non-PPO doctor and let him or her know that for continued care, subsequent itemized bills may be submitted after the initial claim is filed. If filing a claim is delayed, the *Health Plan* may consider the claim if it is submitted within one year after the date of service.

If you use a PPO provider, no claim has to be submitted. Your PPO doctor, *hospital* or other provider will bill the *Health Plan* directly. All you have to do is pay the applicable co-insurance and deductible, if any.

If you use a non-PPO provider, follow these procedures:

1. Obtain a claim form from the Health Plan Office or from the Pension and Health Plan page on the Directors Guild of America, Inc. website.
2. Be sure that you answer all questions about other insurance. Provide the name(s) and address(es) of the other insurance, identifying codes, and the name of the policy holder. Failure to supply full and truthful information about other insurance may constitute fraud.
3. When you are covered under more than one plan, each plan will require a copy of all itemized bills with diagnosis and corresponding payment sheets. A copy of the operative report is required for most surgical procedures. Your surgeon should submit a copy of the operative report.
4. Sign the form.

*Please feel free to call the Health Plan Office if you have any questions on how to file a claim.
(323) 866-2200 or toll-free (877) 866-2200 Extension 401*

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PRESCRIPTION DRUG CLAIMS

If you use an Express Scripts pharmacy, you do not have to file a claim; it is taken care of by the pharmacy. Be sure to show your Express Scripts card to let the pharmacist know that you are covered by this *Health Plan*. Then simply pay the required co-payment at the time of purchase.

If you purchase your prescriptions at a non-Express Scripts participating pharmacy you will not receive the Express Scripts discount, you will have to pay the full amount at the time of purchase, and you will have to file a claim form with Express Scripts for your partial reimbursement. To file a claim, request a claim form from Express Scripts and submit the necessary information and receipts. They will reimburse you for the amount they would have covered at the discounted rate, less the co-payment amount. You can reach Express Scripts at (800) 789-6443. All prescription drug claim forms should be mailed to:

Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439-0873
Attn: Claims Department

If you need a prescription drug claim form, you can write to Express Scripts at the above address, call them at (800) 789-6443, or you may download a claim form from www.express-scripts.com.

DENTAL PLAN CLAIMS

If you use a DeltaPreferred Option (*DPO*) dentist or a non-*DPO* Delta Dental dentist, you do not have to file a claim; it will be taken care of by your Delta Dental dentist. Just be sure to let them know that you participate in Delta Dental. You may want to show your Delta Dental card that has Delta Dental's address and the DGA Plan's group number.

If you do not use a Delta Dental dentist, you (or your dentist) will have to submit the claim directly to Delta Dental.

To file a dental claim, follow these procedures:

- Obtain a claim form from Delta Dental or from the Pension and Health Plan page on the Directors Guild of America, Inc. website.
- Indicate if it is a Predetermination of Benefits claim or an actual claim.
- You should complete the "Employee Section" in full and sign the form.
- Your dentist should complete the "Dentist Section."
- Attach any itemized bills and send the completed form to Delta Dental at:

Delta Dental Plan of California
P.O. Box 7736
San Francisco, California 94120

VISION SERVICE PLAN CLAIMS

If you use a VSP-participating doctor, you do not have to file a claim; it will be taken care of by your service provider. If you do not use a VSP-participating doctor, you will have to file a claim. All vision claim

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

General Provisions

forms should be sent directly to Vision Service Plan at:

**Vision Service Plan
P.O. Box 997105
Sacramento, California 95899-7105**

If you need a vision claim form, you can write to VSP at the above address, call them at (800) 877-7195, or you may download a claim form from www.vsp.com.

▶ CLAIMS AND APPEALS PROCEDURES

The *Health Plan* has long been committed to processing medical claims in a timely manner. This section clarifies your rights under claims and appeals regulations issued by the U.S. Department of Labor for claims filed on or after January 1, 2003.

CLAIMS IN GENERAL

A claim is a request for a *Health Plan* benefit by a participant or beneficiary in accordance with the *Health Plan's* claims procedures. How claims are filed and processed depends on the type of claim. As described above, certain claims, such as dental benefits, must be submitted to the applicable third party claim administrator for the *Health Plan*. Additionally, claims for benefits under the HMO or DMO are submitted to the HMO and DMO, respectively. Other claims are submitted to the Health Plan Office. Each third party administrator, as well as the Health Plan Office, is referred to as a "Claim Administrator." Refer to page 8 for contact information for these different 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 Plan* documents and, where appropriate, *Health Plan* 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 Plan* that are required to be submitted to the Health Plan Office are post-service health care claims. Most other claims under the *Health Plan* will also be post-service health care claims.

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 you of a denial within 30 days after receipt of the claim, unless a 15-day extension is necessary due to circumstances beyond the *Health Plan's* control. If the reason for the extension is because the Claim Administrator does not have enough

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information to decide the claim, the notice will describe the required information and you will have 45 days from the date the notice is received to provide the necessary information. If the claim is for benefits dependent upon a determination that the individual is disabled (i.e. the disability continuation provisions), the Claim Administrator will notify you of the *Health Plan's* decision within 45 days after receipt of the claim unless the Claim Administrator notifies the claimant that an extension of 30 days is necessary due to circumstances beyond the *Health Plan's* control. This initial 30-day extension may be extended another 30 days if the Claim Administrator determines that an extension is needed due to circumstances beyond the *Health Plan's* control and the Claim Administrator notifies you of the extension, including the unresolved issues and any additional information needed.

PRE-SERVICE HEALTH CARE CLAIMS

A pre-service claim is a request for approval of a health care benefit required by the *Health Plan* before service or treatment will be covered in whole or in part. 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. There are relatively few pre-service claims under the *Health Plan*. Examples of pre-service claims are inpatient substance abuse treatment, inpatient mental health treatment, and certain prescription drugs (such as Viagra; growth hormones; Cerezyme; Intravenous Immunoglobulins (IVIG); and Retin-A, Renova, and Differin for individuals under age 11 or over age 29).

There are three types of pre-service health care claims: urgent care claims, non-urgent care claims, and concurrent care claims.

- **Urgent Care Claims** - If the claim is a pre-service claim for urgent health care, you will be notified of the determination as soon as possible, but not later than 72 hours after receipt of the claim. If there is insufficient information for determination, you will be notified of the missing information as soon as possible but not later than 24 hours after receipt of the claim. You will have a reasonable period of time (at least 48 hours) to provide the missing information. You then will receive an eligibility determination within 48 hours after the earlier of (1) the *Health Plan's* receipt of the missing information or (2) the end of the period provided for you to submit the missing information, provided the Claim Administrator will not be required to provide a determination before the original 72-hour period expires.
- **Non-urgent Care Claims** - If the claim is a pre-service claim but is not a claim for urgent health care, you will be notified of a denial within 15 days after receiving the claim, unless a 15-day extension is necessary due to circumstances beyond the *Health Plan'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 you will have 45 days from the date the notice is received to provide the necessary information.
- **Concurrent Care Claims** - 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, you will be notified sufficiently in advance in order to appeal the decision before the benefit is reduced or terminated.

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General Provisions

You may request an extension of the course of treatment beyond the approved time period or number of treatments. If this 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 this request does not involve urgent care, the normal pre-service health care claim rules apply.

If you fail to follow the *Health Plan's* claim procedures for filing a pre-service claim, you will be notified of 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 Plan* 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.

CONTENTS OF DENIAL NOTICES

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

- The specific reason or reasons for the adverse determination;
- Reference to the *Health Plan* provisions on which the determination is based;
- 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; and
- A description of the *Health Plan'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.

A notice of an adverse benefit decision may also include the following:

- If an internal rule or guideline was applied in making the determination, a statement of the rule or guideline will be provided free of charge upon request;
- If the determination is based on a medical necessity or experimental exclusion, a statement that 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 your claim is denied, you have 180 days from receipt of the denial to submit a written appeal. The appeals decision for any claims denied by the Health Plan Office will be conducted by the Benefits Committee of the Board of Trustees of the *Health Plan*. Appeals of claims determined by a Claim Administrator other than the Health Plan Office will be reviewed by such third party Claim Administrator, except appeals of claims reviewed by a third party Claim Administrator for mental health and substance abuse benefits or certain grandfathered prescription drug benefits. Claims for such benefits will be reviewed as follows:

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

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- Post service claims will be reviewed by the Benefits Committee, as described below and;
- Pre-service claims will be reviewed by the Special Committee made up of the *Health Plan's* Administrator, Assistant Administrator and Claims Manager.

You may submit written comments and other information relating to the claim for consideration on appeal. You will be provided, upon request and free of charge, other information relevant to the 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 or her subordinate.

The 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 entity reviewing a claim (whether it is a Third Party Claim Administrator, the Benefits Committee of the Board of Trustees or the Special Committee) will have discretion to deny or grant the appeal in whole or part.

Decisions shall be made in accordance with the governing *Health Plan* documents and, where appropriate, *Health Plan* provisions will be applied consistently with respect to similarly situated claimants in similar circumstances. The entity reviewing a claim (whether it is a third party Claim Administrator, the Benefits Committee of the Board of Trustees or the Special Committee) shall have discretion to determine which claimants are similarly situated in similar circumstances.

DECISIONS ON APPEAL

Reviews of denials by the Health Plan Office will be heard by the Benefits Committee at its next regularly scheduled quarterly meeting. However, if an appeal is received within 30 days before the meeting, the review may 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, you will be notified within five days after the determination.

For appeals of claims denied by a party other than the Health Plan Office, you will receive notice of the appeals decision as follows:

- If the claim is a post-service claim, you will be notified within a reasonable period of time, but not later than 60 days after receipt of the request for review;
- If the claim is a pre-service claim for urgent health care, you will be notified as soon as possible, but not later than 72 hours after receipt of the request for review; and
- If the claim is a pre-service claim that does not involve urgent health care, you 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.

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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 you upon request and free of charge.

CONTENTS OF NOTICE OF DECISION ON APPEAL

Any notice of an adverse determination will include the following:

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

A notice of an adverse determination may also include the following:

- 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 Plan* benefits until the foregoing administrative procedures have been exhausted. Additionally, any such suit must be brought within one year after your benefits appeal is denied.

SPECIAL RULE FOR AUTHENTICITY CLAIMS

Please note that the Authenticity Subcommittee is responsible for deciding that benefits should not have been paid for a period when contributions were not authentic. Appeals for such claims will be reviewed by the Legal and Delinquency Committee. Such claims and appeals will otherwise be administered in accordance with the claims procedures for post-service claims.

If you have any questions regarding the claims and appeals procedures, please contact the Health Plan Office.

If payment of any benefit under the *Health Plan* cannot be effectuated because the *Health Plan's* records do not include the individual's current address or the individual does not cash the check from the *Health Plan* by the last day of the Plan Year following the year the claim was incurred, then the *Health Plan* shall consider such benefit to be forfeited. The *Health Plan* shall reinstate the forfeited benefit of any individual who presents himself or herself to the *Health Plan* after such forfeiture has occurred, although such reinstatement shall not include any adjustment for increases or decreases in the benefit for the period between the date of forfeiture and the date of reinstatement.

RECOVERY INCENTIVE PROGRAM

Whenever you receive a bill, be sure to check it carefully. If you find you have been billed incorrectly, whether due to an overcharge or for services or supplies which were not received, you should report this to the Health Plan Office. If you are able to arrange a recovery or reduction in the erroneous charges, the *Health Plan* will give you a cash incentive. The amount of the incentive varies as follows:

- For an overcharge that is less than \$100, the cash incentive will be the actual amount of the overcharge.
- For an overcharge of \$100 or more, the cash incentive will be 50% of the overcharge, but not more than \$500 (50% of \$1,000) or less than \$100.
- An overcharge greater than \$1,000 will be reviewed by the Board of Trustees for consideration of an additional incentive over the \$500 maximum.

This program is our attempt to correct billing problems, thus reducing your out-of-pocket expenses and those of the *Health Plan*. Check your bills and make sure you have received all services and supplies which were listed. Please contact the Health Plan Office for further details.

THIRD PARTY REIMBURSEMENT

“Third Party” means a person or organization other than the participant who suffers a loss.

No benefits will be paid under any coverage of the *Health Plan* with respect to an *injury* or *sickness* for which a Third Party may be liable or legally responsible. However, the *Health Plan* will pay benefits according to the terms of the policy on the condition that the participant and/or beneficiary agrees, in writing, to the following:

- to give the *Health Plan* written notice whenever a claim against a Third Party or an insurer of the Third Party is made for damages as a result of an *injury* or *sickness*; and
- to reimburse the *Health Plan* in accordance with these provisions for any benefit paid by the *Health Plan* when a recovery is obtained from or on behalf of the Third Party or the insurer of the Third Party beginning with the first dollar of recovery in an amount up to but not exceeding the recovery.

In addition, the participant and/or dependent that experienced an *injury* or *sickness* for which a Third Party may be legally responsible must execute an assignment in favor of the *Health Plan* for the amount to which the *Health Plan* is entitled.

The *Health Plan* has the right of first reimbursement from the amounts paid by a Third Party, before attorneys’ fees and/or even if you have not fully recovered your total loss, but the amount of reimbursement to the *Health Plan* will not exceed the lesser of:

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- the amount actually paid by the *Health Plan*; or
- the amount of the recovery from or on behalf of the Third Party.

Notwithstanding the foregoing, if any payment is made under the *Health Plan* as a result of any *injury* caused by a Third Party, the Board of Trustees may take such actions as the Board, in its discretion, feels would best serve the *Health Plan*. Such actions include, but are not limited to, any or all of the following:

- The *Health Plan* may seek to have any payment by a Third Party made payable to the *Health Plan* in lieu of, or in addition to, you or your beneficiaries, assigns, or representatives.
- The *Health Plan* may refuse to provide you, your dependent(s) and beneficiaries any benefits under the *Health Plan* if you (i) refuse to execute an agreement agreeing to reimburse the *Health Plan*; (ii) fail to reimburse the *Health Plan*; or (iii) fail to cooperate in helping the *Health Plan* collect reimbursement from you or a Third Party.

ERISA REQUIRED INFORMATION

Name of Plan. This Plan is known as the Directors Guild of America–Producer Health Plan.

Type of Plan. This group health plan is maintained for the purpose of providing medical, prescription drug, dental, vision and wellness benefits for participants of the Directors Guild of America–Producer Health Plan and their covered dependents.

Plan Administrator and Sponsor. The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the plan is reported to government agencies and disclosed to plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

The Health Plan Office will provide you, upon written request, information as to whether a particular employer or union is a sponsor of the plan and the address of the employer or union.

Name and Address of Board of Trustees. The Board of Trustees consists of an equal number of guild and management representatives, selected by the employers and the guild, in accordance with the Trust Agreement which relates to this plan.

All of the Trustees should be addressed at:

Directors Guild of America–Producer Health Plan
8436 West Third Street, Suite 900
Los Angeles, California 90048-4189
Telephone (323) 866-2200
Toll Free Outside Los Angeles area (877) 866-2200
Fax (323) 653-2375

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As of July 1, 2003 the Trustees of this Plan are:

Producer Trustees:	Guild Trustees:
Ms. Helayne Antler	Mr. Warren Adler
Mr. Steven E. Berkowitz	Mr. Lawrence Auerbach
Mr. J. Nicholas Counter III	Ms. Yudi Bennett
Mr. Mark B. Crowley	Mr. Scott Berger
Ms. Pamela A. DiGiovanni	Mr. Burt Bluestein
Mr. J. Keith Gorham	Mr. Gil Cates
Mr. Joel M. Grossman	Ms. Lee Shallat Chemel
Mr. Stephen M. Koppekin	Ms. Anita Cooper-Avrick
Mr. Hank Lachmund	Mr. Mel Damski
Ms. Carol A. Lombardini	Mr. Phillip M. Goldfarb
Mr. Matthew Miller	Mr. Robert Ellis Miller
Ms. Corrinne L. Notkin	Ms. Nina K. Noble
Mr. David Pill	Mr. John Rich
Ms. Gigi Wynne Porter	Mr. Jay D. Roth
Mr. Alan H. Raphael	Mr. Jack Shea
Ms. Jennifer Rubin	Mr. Abby Singer
Mr. Stephen Steinbrecher	Mr. Jud Taylor

IRS Identification Numbers. The taxpayer identification number assigned to the plan by the Internal Revenue Service is 23-7067289. The plan number is 501.

Agent for Service of Legal Process. The name and address of the agent designated for the service of legal process is:

Mr. Gavin S. Gervis
Administrator
Directors Guild of America-Producer Health Plan
8436 West Third Street, Suite 900
Los Angeles, California 90048-4189

Legal process may also be served on a Plan Trustee at the address listed on page 86.

Collective Bargaining Agreements. Contributions to this plan are made on behalf of each employee in accordance with the Collective Bargaining Agreements between the Directors Guild of America, Inc. and employers in the industry.

The Health Plan Office will provide you, upon written request, copies of the Collective Bargaining Agreements. The Collective Bargaining Agreements are also available for examination at the Health Plan Office.

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Source of Contributions. The benefits described in this book are provided through employer contributions to this Plan as well as participants' premiums for dependent coverage and/or self-pay coverage. The amount of employer contributions to this plan is determined by the provisions of the Collective Bargaining Agreements. The Collective Bargaining Agreements require contributions to this plan at a fixed percentage of the participant's earnings. The minimum earnings will be adjusted each January 1.

The Health Plan Office will provide you, upon written request, information as to whether a particular employer is contributing to this plan on behalf of participants working under a Collective Bargaining Agreement.

Trust Fund. The Trust's assets and reserves are held in trust with Union Bank of California by the Board of Trustees of the Directors Guild of America–Producer Health Plan.

Identity of Providers of Benefits. The medical, prescription drug, dental, and vision benefits are self-funded and are provided by the Directors Guild of America–Producer Health Plan. The PPO network in California is provided by special arrangement through Blue Cross. The PPO network outside California is provided by special arrangement through Private Healthcare Systems (PHCS). Vision benefits are provided by Vision Service Plan (VSP). Dental benefits are provided by Delta Dental Plan of California. Prescription Drug benefits are provided by Express Scripts. Blue Cross, PHCS, VSP, Delta Dental, and Express Scripts provide some administrative services to the Plan but do not guarantee benefits. However, benefits under the HMO and DMO options are not self-funded and are paid for by the respective HMO and DMO carriers.

The Directors Guild of America–Producer Health Plan is fully liable for all benefits under the Plan.

Plan Year. The records of the plan are kept separately for each Plan Year. The Plan Year is the calendar year.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may charge a reasonable fee for the copies.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

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Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Reduction or elimination of exclusionary periods or coverage for preexisting conditions under your group *Health Plan*, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group *Health Plan* or health insurance issuer when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court but only if you complete the plan's claims and appeals procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

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Assistance with Your Questions

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

▶ **WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998**

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.

▶ **A FINAL WORD**

This booklet is the plan document and summary plan description for the *Health Plan*. It describes the Medical, Prescription Drug, Dental and Vision benefits available to eligible participants of the *Health Plan*.

False or Fraudulent Claims

Anyone who submits any false or fraudulent claim or information to the *Health Plan* may be subject to criminal penalties including a fine or imprisonment or both as well as damages in a civil action under California or federal law. Furthermore, the Board of Trustees reserves the right to impose such restrictions upon the payment of further benefits to any such participant or dependent as may be necessary to protect the *Health Plan* including the deduction from such future benefits of amounts owed to the *Health Plan* because of the payment of any false or fraudulent claim. The participant or dependent must pay the *Health Plan* for all its legal and collection costs as well as benefit payments made (with interest). If it is determined that a participant became eligible for *Health Plan* benefits as a result of earnings which are determined to be non-covered earnings, the participant is obligated to refund all benefits received in excess of contributions by the participant's employer to the *Health Plan* on the participant's behalf. If the participant also loses pension credit as a result, improper pension contributions may be utilized as an offset against benefits paid to the participant.

Contribution Audit Program

The *Health Plan* has a contribution audit program to ensure that employer contributions are submitted for eligible employment. If it is determined that a member's eligibility is based on

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

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non-covered employment, the *Health Plan* will take corrective action. This may include retroactively removing earned eligibility or reducing eligibility (e.g. moving a participant's coverage from the DGA Premier Choice Plan to the DGA Choice Plan), seeking reimbursement of health benefits paid as a result of such non-covered employment and recovering such benefits from pension contributions.

NOTE: Self-employed individuals are not eligible for *Health Plan* participation with respect to their self-employment income. An individual is considered self-employed if he or she is (1) a partner; (2) a proprietor; or (3) a member of a limited liability company who is not a bona fide employee of the limited liability company.

Employer Contributions

Health Plan participation is based on the receipt of the required level of contributions from your employer. The failure to receive such contributions in a timely fashion may jeopardize your health coverage. Accordingly, it is crucial that you ensure that your employer makes *Health Plan* contributions on your behalf in accordance with the Collective Bargaining Agreements. You must notify the Health Plan Office immediately if you feel that appropriate contributions to the *Health Plan* on your behalf have not been made. The *Health Plan* has a Delinquent Employer Hotline you may call to anonymously report an employer if you believe that contributions are not being made correctly on your behalf. You can reach the hotline at (323) 866-2200 extension 711 at the Health Plan Office.

Important Notice

- Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the *Health Plan*. The Trustees reserve the right to amend, modify or discontinue all or part of this *Health Plan* at any time.
- Employees of the *Health Plan* have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by employees of the *Health Plan* are not binding upon the Trustees and cannot enlarge or change such benefits or eligibility rules. In accordance with the terms of the Trust Agreement, the Trustees reserve the right to change the nature and extent of benefits provided by the *Health Plan* and to amend the rules governing eligibility at any time.
- The benefits described in this booklet, while intended to remain in effect indefinitely, can be amended or terminated at any time by the Trustees. These are not guaranteed lifetime benefits.

Note: All words and phrases appearing in italics are defined in the Glossary, beginning on page 94.

Glossary

Glossary

Any word in the male gender applies equally to the female gender unless a distinction is specified. The definitions in this section apply whether or not the defined words are capitalized when used in this booklet.

ACCIDENT means an accidental injury as it applies to benefits, resulting from a fall, blow, cut or bite.

ACUPUNCTURE means the stimulation of a point or points on or near the surface of the body, by the insertion of needles. The purpose of acupuncture treatment is to prevent or modify the patient's perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body.

ALLOWABLE CHARGE means the lesser of the two following amounts:

1. the provider's charge; or
2. the reasonable and customary charge.

AMBULATORY SURGICAL CENTER - The center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The type of procedures performed must permit discharge from the center on the same "working day." The center will not qualify as a hospital if:

- it is not state-licensed nor Medicare-certified as an ambulatory surgical facility;
- it is maintained as an office by a physician for the practice of medicine; or
- it is maintained as an office for the practice of dentistry.

ASSISTANT SURGEON - Services of an assistant surgeon are eligible for benefits in those cases where an assistant surgeon is medically necessary. An assistant surgeon is considered medically necessary when a procedure is at a level of technical surgical complexity that the assistance of another surgeon is required. Services of operating room technicians are included in the surgeon or operating room facility charges and are not eligible for separate benefits.

BIOFEEDBACK TRAINING/THERAPY means a technique intended to teach patients self-regulation of certain physiologic functions not normally considered being under voluntary control. It may be covered under Outpatient Psychiatric Care, or for some conditions such as hypertension, under the physical therapy benefit. To determine which conditions are covered for biofeedback treatment, you may contact the Health Plan Office.

CHIROPRACTIC CARE means treatment by manual or mechanical means of a structural imbalance, distortion, or subluxation, in the vertebral column or elsewhere in the body. The following services are NOT covered when rendered or requested by a chiropractor or other provider:

1. Care of conditions other than musculoskeletal disorders;
2. Chiropractic treatment to the feet, including x-rays and orthotics;
3. Studio calls;
4. On-site calls;
5. Home visits;
6. Exercise at a gym or similar facility; or
7. All diagnostic tests except for musculoskeletal x-rays even if such tests are administered or interpreted by a medical doctor.

COBRA means Consolidated Omnibus Budget Reconciliation Act of 1985.

COMPLEMENTARY AND ALTERNATIVE MEDICINE means a group of diverse medical and health care systems, practices and products that are not presently considered to be a part of conventional medicine including, but not limited to, those identified by the National Center for Complementary and Alternative Medicine.

COMPLICATIONS OF PREGNANCY means:

1. Conditions requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy. Examples are acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. False labor, occasional spotting, physician-prescribed rest, morning sickness, hyperemesis gravidarum and pre-eclampsia are not considered “complications of pregnancy;”
2. Non-elective cesarean section;
3. Ectopic pregnancy which is terminated; or
4. Spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

COSMETIC SURGERY is considered to be any reconstructive surgery that attempts to change physical appearance and does not simultaneously correct or improve some disease or bodily impairment.

Cosmetic surgeries and related charges will not be considered covered expenses except when:

1. reconstructive surgery is performed to correct a deformity created by previous surgery;
2. reconstructive surgery is performed to correct a deformity resulting from accidental bodily injury; or
3. reconstructive surgery is performed to correct a congenital deformity.

COST-EFFICIENT - A medical or dental service or supply will be considered cost-efficient if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

COVERED EARNINGS means compensation paid to a participant by an employer on which that employer is required to make contributions to the Health Plan in accordance with the collective bargaining agreements.

COVERED EXPENSES means hospital, medical, dental, vision, prescription drug and related costs incurred by those covered by the Health Plan that qualify for reimbursement through the Health Plan. Covered expenses cannot exceed allowable charges.

CUSTODIAL CARE means care which is designed to help a person in the activities of daily living when continuous attention by trained medical or paramedical personnel is not necessary. Custodial care may involve:

1. preparation of special diets;
2. supervision of medication that can be self-administered; or
3. assisting the person in getting in or out of bed; to walk; to bathe; to dress; to eat; or to use the toilet.

Glossary

DOMESTIC PARTNERS are same-sex adults who share an emotional, physical and financial relationship, but are prohibited by law from marrying and have a completed domestic partner affidavit (in such form as the Health Plan determines is appropriate to evidence domestic partner status) on file at the Health Plan Office.

DPO means the DeltaPreferred Option. Details are explained in the Dental section of this booklet.

DURABLE MEDICAL EQUIPMENT will be considered to be equipment that satisfies all the following conditions:

1. the most cost-efficient equipment for medically necessary treatment of an injury or illness;
2. it can stand repeated use;
3. it is generally not useful to a person in the absence of sickness or injury;
4. it is appropriate for use in the home; and
5. it is used to improve the functioning of a malformed body part, or to compensate for loss of ambulation due to physical impairment.

Elevators, stair climbing wheelchairs, stair lifts, ramps, bedside tables, car seats or similar items for comfort or convenience are not considered to be durable medical equipment.

EARNED COVERAGE means coverage granted for earnings resulting from work performed in a DGA capacity pursuant to a collective bargaining agreement between the Directors Guild of America, Inc. and Producer representatives in the motion picture, television and commercial production industries and for which contributions are due to the Health Plan. If the earnings are based on current work a participant has active earned coverage. If the earnings are based on residuals a participant has inactive earned coverage. The distinction between active earned coverage and Inactive earned coverage generally only applies to the coordination of benefits for those participants receiving medicare benefits.

EXPERIMENTAL OR INVESTIGATIONAL - No procedure, treatment, supply, device, equipment, facility or drug, or expense in connection therewith, which is experimental or investigational in nature (unproven) is considered medically necessary. A procedure, treatment, supply, device, equipment, facility or drug will be considered non-investigational (and thus eligible for coverage) if it meets all of the following criteria:

1. The procedure, treatment, supply, device, equipment, facility, or drug has final approval from the appropriate government regulatory bodies.
2. The scientific evidence permits conclusions concerning effect of the technology on health outcomes.
 - The evidence should consist of well-designed and well-conducted studies in peer-reviewed English-language journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
 - Opinions and positions of national professional medical associations, consensus panels or other technology evaluation bodies, are evaluated according to the scientific quality of the supporting evidence and rationale.
3. The procedure, treatment, supply, device, equipment, facility or drug improves the net health outcome. Its beneficial effects should outweigh any harmful effects.
4. The procedure, treatment, supply, device, equipment, facility or drug is as beneficial and as cost-efficient as any established alternatives.

5. The improvement is attainable and shows improvement outside the investigational setting (i.e., it is being performed in additional hospitals/facilities other than the hospitals/facilities doing the investigation). When application of a procedure, treatment, supply, device, equipment, facility or drug is limited to highly specialized care by providers such as thoracic surgeons, neurosurgeons and intensive care units (usually requiring highly sophisticated technologies and facilities, such as at university-affiliated or teaching hospitals that have extensive diagnostic and treatment capabilities), it must be in regular use in such facilities and not be restricted to a single center.

HEALTH PLAN means the benefits provided by the Directors Guild of America - Producer Health Plan. The Plan is subject to change or termination by the Board of Trustees at any time.

HOME HEALTH CARE means a program for care and treatment of a sick or injured person in his/her home by a Home Health Care Agency, such as medically necessary home infusion of prescription drugs. The referring physician must provide a written statement specifying medical necessity and the type of services to be rendered by the Home Health Care Agency prior to the start of care.

HOSPICE means an agency which provides medical, health care services and Medical Social Services for the palliative and supportive care and treatment of terminally ill individuals. The agency must meet the following requirements:

1. Provides 24-hour, 7-days-a-week service;
2. Provides a program of services under direct supervision of a physician or licensed RN;
3. Maintains full and complete records of all services provided; and
4. Be established and operated in accordance with the applicable laws and regulations of its local jurisdiction.

HOSPITAL means an establishment which:

1. holds a license as a hospital (if required in the state);
2. operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
3. provides around-the-clock nursing service;
4. has a staff of one or more physicians available at all times;
5. provides organized facilities for diagnosis and surgery;
6. is not primarily a clinic, nursing, rest or convalescent home or a similar establishment; and
7. is not, other than incidentally, a place for treatment of drug addiction.

The nursing service must be by registered or graduate nurses on duty or call. The surgical facilities may be either at the hospital or at a facility with which it has a formal arrangement.

A hospital also includes:

- a psychiatric health facility as defined in Section 1250.2 of the California Health and Safety Code, when service is rendered there for psychiatric disorders or mental conditions; and
- a state licensed or Medicare-approved ambulatory surgical center (see ambulatory surgical center on page 45).

Glossary

Confinement in a special unit of a hospital used primarily as a nursing, rest or convalescent home will not be deemed to be confinement in a hospital.

INJURY means bodily injury caused by an accident.

INTENSIVE CARE UNIT means a section within a hospital which operates exclusively for the care of critically ill patients and provides special supplies, equipment and constant observation and care by registered nurses or other highly trained hospital personnel. It is not a hospital facility maintained for the purpose of providing normal post-operative recovery treatment.

INTERDISCIPLINARY TEAM means the primary care unit which develops the overall plan of care and provides for the patient and his immediate family. The team must consist of a physician and a licensed RN. The team may also contain an RN or LPN utilized as a visiting nurse in the patient's home and a licensed social worker (social worker must have a minimum of one year's experience in working with the terminally ill and their families).

MEDICAL SOCIAL SERVICES means those services rendered in connection with the terminal illness of a patient by a social worker under the direction of a physician. Such services include, but are not limited to:

1. Assessment of the social, psychological and family problems related to or arising from the illness and treatment.
2. Appropriate action and utilization of community resources to assist in resolving such problems.

MEDICALLY NECESSARY - A treatment, service or supply is medically necessary when it is:

1. consistent with generally accepted medical practice within the medical community for the diagnosis or direct care of symptoms, sickness or injury of the patient, or for routine screening examination under the wellness benefit, where and at the time the treatment, service or supply is rendered (the determination of "generally accepted medical practice" is the prerogative of the Health Plan through consultation with appropriate authoritative medical, surgical, or dental practitioners);
2. ordered by the attending licensed physician (or, in the case of dental services, ordered by the dentist), and not solely for the convenience of the participant, his or her physician, hospital or other health care provider;
3. consistent with professionally recognized standards of care in the medical community with respect to quality, frequency and duration; and
4. 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.

Any treatment, service or supply that is not a valid treatment or diagnostic test recognized by an established medical society in the United States is not considered medically necessary treatment.

"Off label drug use" is defined as the use of an FDA-approved drug for other uses than those listed in the FDA-approved labeling or in treatment regimens or patient populations that are not included in approved labeling. Off label drug use will be considered medically necessary when all

of the following conditions are met:

1. the drug is approved by the FDA; and
2. the drug is recognized by the American Hospital Formulary Service Drug Information, the U.S. Pharmacopoeia Dispensing Information, Vol. I, or two articles from major peer-reviewed journals that have validated and uncontested data supporting the proposed use for the specific medical condition as safe and effective; and
3. the drug is medically necessary to treat the specific medical condition, including life-threatening conditions or chronic and seriously debilitating conditions.

If the off label use is determined to be medically necessary, its use shall also be determined to be “non-investigational” for the purposes of benefit determination.

This policy shall not be construed to require coverage for any drug when the FDA has determined its use to be contraindicated.

MEDICARE is insurance that is provided by the Federal Health Insurance for the Aged and Disabled Act.

MIDWIFE means a state-licensed midwife or a licensed registered nurse that is state-certified or certified as a midwife by the American College of Nurse Midwives, the North American Registry of Nurse Midwives or the American College of Midwives Certification Council.

NECESSARY TREATMENT - See Medically Necessary.

OCCUPATIONAL THERAPY means the application of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose function is impaired due to physical or psychiatric sickness or injury, to achieve optimum recovery.

OPEN ENROLLMENT PERIOD means the period during which you can make a change to your coverage under the Health Plan (such as adding or dropping dependents or, if you are in California, selecting the HMO or DMO options) to be effective for the next period of earned coverage, or, if you are on self-pay, retiree carry-over or Certified Retiree status, the anniversary of your coverage.

PHYSICAL THERAPY means treatment provided by a registered physical therapist, certified occupational therapist, or licensed practitioner of the healing arts acting within the scope of his/her license utilizing physical agents and methods to assist in rehabilitation and restoration of normal bodily function after sickness or injury.

PHYSICIAN means a licensed practitioner of the healing arts acting within the scope of his/her license. As defined under the Health Plan, the physician may not be a participant or a member of a participant’s “immediate family.” “Immediate family” means the spouse, children, brothers, sisters or parents of a participant.

Physician also means a midwife with respect to treatment, service or care rendered by such midwife within the lawful scope of practice of a midwife.

Glossary

PPO means Preferred Provider Organization.

PSYCHIATRIC DISORDERS means the conditions listed in the Mental Disorders section of the current edition of the World Health Organization's International Classification of Diseases, as published by the Commission of Professional and Hospital Activities.

REASONABLE AND CUSTOMARY CHARGE means a charge or fee level that is equal to or less than the charge that 90% of the physicians of a similar specialization in a given geographical area would charge for a specified procedure. Reasonable and customary charges are determined from a database that identifies the cost of each procedure or service by geographic area. Schedules of maximum reasonable and customary charges are adjusted periodically to reflect changes in physicians' charges.

SICKNESS means illness or disease which causes loss covered by the Health Plan. The loss must commence while the person is insured under the Health Plan. Pregnancy is considered a sickness for participants and covered spouses. Pregnancy of a child of a participant who is otherwise a covered person is not covered, except for complications of pregnancy.

TERMINALLY ILL - A participant is considered terminally ill if he or she has a medical condition for which no effective treatment exists (or for whom known effective treatments have been tried without success) and is certified by a physician as unlikely to survive for a specific length of time. For hospice benefits, the life expectancy must be 6 months or less.

TOTAL DISABILITY is defined as inability to engage in any occupation for wage or profit for which you are reasonably qualified by reason of education, training or experience. The inability must be as a result of injury or sickness. It must also be verified by an attending physician's statement.

As used for extension of coverage, total disability is defined as:

- For an active or self-pay participant, inability to perform the substantial and material duties of his occupation or employment. The inability must be as a result of injury or sickness.
- For a retired participant, and for a dependent, inability to engage in the substantial and material activities engaged in prior to the start of disability. The inability must be a result of injury or sickness.

As used for COBRA and self-pay purposes, total disability means that the individual has been approved for and is receiving Social Security disability benefits.

VISION THERAPY - Vision therapy (orthoptic training) is considered medically necessary when prescribed by a physician for the treatment of strabismus and other disorders of binocular eye movements or of strabismic amblyopia.

WELLNESS BENEFIT covers health and wellness programs such as routine physical examinations, smoking cessation, nutritional counseling, weight-loss programs, immunizations, well woman care and hearing aids. Please see page 53 for a more complete explanation of what is and is not covered under the wellness benefit.

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