

HEALTH PLAN SUMMARY PLAN DESCRIPTION UPDATES

The changes summarized below supersede the provisions described in the March 2025 Summary Plan Description.

We have organized the changes by page number, so that you can easily see the pages to which changes were made. Under the **Summary of Change** column, you will find a description of the benefit change and a reference to the section where the change occurs, followed by the language being changed.

INDEX OF CHANGES

Pages	Summary of Change	Effective Date																
1	<p><i>Change reflects update in the Section 1, Medical Benefits chart for the All-Inclusive Network Out-of-Pocket Limit.</i></p> <p><i>In Article I, Section 1, Medical Benefits, all references to the All-Inclusive Network Out-of-Pocket Limit are changed to the following:</i></p> <p><i>\$10,600 per person/ \$21,200 per family</i></p>	1/1/2026																
3	<p><i>Change removes per lens per eye language.</i></p> <p><i>Article I, Section 4 titled Vision Benefits on page 3 is amended to read as follows:</i></p> <table border="1"> <thead> <tr> <th></th> <th>Service or Supply Frequency</th> <th>Network Benefit</th> <th>Non-Network Maximum Benefit*</th> </tr> </thead> <tbody> <tr> <td>Exams</td> <td>Once per calendar year</td> <td>\$30 co-payment</td> <td>\$45 co-payment</td> </tr> <tr> <td>Frames</td> <td>Once every other calendar year</td> <td>\$220 allowance; or \$240 allowance for featured frame brands</td> <td>\$70 allowance</td> </tr> <tr> <td>Lenses</td> <td>Once per calendar year</td> <td>\$200 allowance</td> <td> Single Vision Lenses \$30 Lined Bifocal Lenses \$50 Lined Trifocal Lenses \$65 Lined Contact Lenses \$105 allowance (elective) \$210 allowance (Medically Necessary) </td> </tr> </tbody> </table> <p><i>*after deducting applicable Network Co-Payment amount</i></p>		Service or Supply Frequency	Network Benefit	Non-Network Maximum Benefit*	Exams	Once per calendar year	\$30 co-payment	\$45 co-payment	Frames	Once every other calendar year	\$220 allowance; or \$240 allowance for featured frame brands	\$70 allowance	Lenses	Once per calendar year	\$200 allowance	Single Vision Lenses \$30 Lined Bifocal Lenses \$50 Lined Trifocal Lenses \$65 Lined Contact Lenses \$105 allowance (elective) \$210 allowance (Medically Necessary)	9/5/2025
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4	<p><i>Change creates the Paid Parental Leave Benefit for qualifying participants covered under the Health Plan.</i></p> <p>Article I, Schedule of Benefits is amended to add a new Section 5 titled Paid Parental Leave Benefits as follows:</p> <p>Section 5. Paid Parental Leave Benefits</p> <p>See Article VIII titled <i>Paid Parental Leave Benefits</i> for more information.</p>	7/1/2025
7-10, 49	<p><i>Change reflects increase in minimum earnings threshold for Health Plan coverage to align with wage increases negotiated in DGA Collective Bargaining Agreements.</i></p> <p>The DGA Choice Plan minimum earnings threshold for earnings periods beginning in 2026 increases from \$39,820 to \$41,215.</p> <p>The DGA Premier Choice Plan minimum earnings threshold for earnings periods beginning in 2026 increases from \$129,150 to \$133,670.</p>	1/1/2026
27	<p><i>Change reflects update to the All-Inclusive Network Out-of-Pocket Limit for the DGA Gold Plan and DGA Silver Plan.</i></p> <p>In Article III, Section 4(d)(1)(D) and Article III, Section 4(d)(2)(D), All-Inclusive Network Out-Of-Pocket Limit, the first sentence is replaced as follows:</p> <p><u>Network:</u></p> <p>\$10,600 per individual per Plan Year/ \$21,200 per family per Plan Year</p>	1/1/2026
28	<p><i>Change reflects update to the All-Inclusive Network Out-of-Pocket Limit for the DGA Bronze Plan.</i></p> <p>In Article III, Section 4(d)(3)(D), All-Inclusive Network Out-Of-Pocket Limit, the first sentence is replaced as follows:</p> <p><u>Network:</u></p> <p>\$10,600 per individual per Plan Year/ \$21,200 per family per Plan Year (includes Deductibles, Co-Payments and Co-Insurance for medical claims)</p>	1/1/2026
47-48	<p><i>Change reflects update to the All-Inclusive Network Out-of-Pocket Limit.</i></p> <p>Article IV, Section 1(i) is amended to read in its entirety as follows:</p> <p>(i) Out-of-Pocket Limit</p> <p><i>The Health Plan limits the amount of Co-Insurance and other out-of-pocket expenses you and your dependents pay for covered services in a calendar year.</i></p>	1/1/2026

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Pages	Summary of Change	Effective Date
48 (cont'd)	<p><i>The Out-of-Pocket Limit is based on Covered Expenses incurred within the corresponding calendar year, not when a claim is paid by the Health Plan.</i></p> <p><i>The Out-of-Pocket Limit is the maximum amount of Covered Expenses that a participant is required to pay after any applicable Deductibles and Co-Payments. A new Out-of-Pocket Limit begins each calendar year and applies separately to each family member. In addition, the Network and Non-Network Out-of-Pocket Limits are calculated separately.</i></p> <p><i>The Deductibles and Out-of-Pocket Limit are higher under the DGA Bronze Plan (see the DGA Bronze Plan section beginning on page 27) but work in the same manner.</i></p> <p><i>Certain expenses do not count towards reaching the Out-of-Pocket Limit. These include:</i></p> <ul style="list-style-type: none"> • <i>Deductibles;</i> • <i>prescription drug expenses;</i> • <i>emergency room Co-Payments;</i> • <i>Non-Network Hospital Co-Payments (other than Non-Network Emergency Services, Emergency or non-Emergency Services received from a Non-Network provider at certain Network facilities, and air ambulance services by a Non-Network provider);</i> • <i>charges in excess of Reasonable and Customary Allowed Amounts;</i> • <i>non-Covered Expenses;</i> • <i>dental benefits;</i> • <i>vision benefits, including glasses and contact lenses; and</i> • <i>charges, including Co-Payments, incurred at a UCLA/EIMG Health Center.</i> <p><i>The All-Inclusive Network Out-of-Pocket Limit is a comprehensive out-of-pocket maximum which includes your Deductibles, Co-Payments and Co-Insurances on Covered Expenses provided by Network providers in a calendar year.</i></p> <p class="list-item-l1">(1) <i>Network Expenses</i></p> <p><i>The Health Plan has two separate Network Out-of-Pocket Limits:</i></p> <ul style="list-style-type: none"> • <i>The Co-Insurance Maximum for Network expenses incurred in a calendar year under both the DGA Premier Choice Plan and the DGA Choice Plan is \$1,000. The Co-Insurance Maximum for Network expenses incurred in a calendar year under the DGA Bronze Plan is \$10,600.</i> • <i>The All-Inclusive Network Out-of-Pocket Limit is \$10,600 per individual and \$21,200 per family. This comprehensive limit includes all out-of-pocket costs: Deductibles, Co-Payments and Co-Insurance.</i> <p><i>Under the DGA Premier Choice and DGA Choice Plans, your Deductible is \$325 for individual coverage and \$975 for family coverage (two or more</i></p>	1/1/2026

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Pages	Summary of Change	Effective Date
48 (cont'd)	<p><i>dependents). That means you pay the first \$325 of medical claims for individual coverage or \$975 for family coverage (two or more dependents). Under the DGA Bronze Plan, your Deductible is \$750 for individual coverage or \$2,250 for family coverage (two or more dependents).</i></p> <p><i>After you satisfy the Deductible, you pay 10% of Covered Expenses for Network claims under the DGA Premier Choice and DGA Choice Plans. Under the DGA Bronze Plan, you pay 30% of Covered Expenses. This is your Co-Insurance. When your Co-Insurance reaches \$1,000 per individual under the DGA Premier Choice or the DGA Choice Plans and 10,600 per individual under the DGA Bronze Plan, the Health Plan will pay 100% of Covered Expenses for the remainder of the calendar year. That means you do not have to pay any additional Co-Insurance for the rest of the year.</i></p> <p><i>Under the All-Inclusive Network Out-of-Pocket Limit, you will continue to pay any Co-Payments until you reach: \$10,600 per individual and \$21,200 per family.</i></p> <p><i>Currently, the only Health Plan Network Co-Payments are prescription drug Co-Payments, the \$50 emergency room Co-Payment, and the Co-Payment for care provided through the UCLA Health/EIMG clinics and related referrals.</i></p> <p>(2) Non-Network Expenses <i>The Out-of-Pocket Limit for Non-Network expenses for the DGA Premier Choice Plan is \$12,500.</i></p> <p><i>The Out-of-Pocket Limit for Non-Network expenses for the DGA Choice Plan is \$20,000.</i></p> <p><i>There is no Out-of-Pocket Limit for Non-Network expenses for the DGA Bronze Plan.</i></p>	1/1/2026
49	<p><i>Change reflects update to the All-Inclusive Network Out-of-Pocket Limit for the DGA Premier Choice Plan and DGA Choice Plan.</i></p> <p>In Article IV, Section 2(a) DGA Premier Choice & Choice Plans all references to the All-Inclusive Network Out-of-Pocket Limit are changed to the following:</p> <p>\$10,600 per person / \$21,200 per family.</p>	1/1/2026

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50	<p><i>Change reflects update to the All-Inclusive Network Out-of-Pocket Limit for the DGA Gold, DGA Silver and DGA Bronze Plans.</i></p> <p>In Article IV, Section 2(b) Self-Pay Plans all references to the Calendar Year All-Inclusive Network Out-of-Pocket Limit are changed to the following:</p> <p>\$10,600 per person / \$21,200 per family.</p>	1/1/2026																
78	<p><i>Change adds language to indicate existing coverage of initial diagnostic workups to determine the cause of infertility.</i></p> <p><i>Article IV, Section 10(30) titled What's Not Covered Under Medical Benefits on page 78 is amended to read in its entirety as follows:</i></p> <p><i>30. Infertility treatment that is not received and/or provided through Carrot or that is in excess of the limits specified. However, an initial diagnostic workup to determine the cause of infertility can be covered prior to the start of any infertility treatment.</i></p>	9/5/2025																
97	<p><i>Change removes per lens per eye language.</i></p> <p><i>Article VII, Section 1 titled Co-Payments and Allowances on page 97 with the Non-Network Maximum Benefit column in the chart below is amended to read as follows:</i></p> <table border="1"> <thead> <tr> <th></th> <th>Service or Supply Frequency</th> <th>Network Benefit</th> <th>Non-Network Maximum Benefit*</th> </tr> </thead> <tbody> <tr> <td>Exams</td> <td>Once per calendar year</td> <td>\$30 co-payment</td> <td>\$45 co-payment</td> </tr> <tr> <td>Frames</td> <td>Once every other calendar year</td> <td>\$220 allowance; or \$240 allowance for featured frame brands</td> <td>\$70 allowance</td> </tr> <tr> <td>Lenses</td> <td>Once per calendar year</td> <td>\$200 allowance</td> <td>Single Vision Lenses \$30 Lined Bifocal Lenses \$50 Lined Trifocal Lenses \$65 Lined</td> </tr> </tbody> </table>		Service or Supply Frequency	Network Benefit	Non-Network Maximum Benefit*	Exams	Once per calendar year	\$30 co-payment	\$45 co-payment	Frames	Once every other calendar year	\$220 allowance; or \$240 allowance for featured frame brands	\$70 allowance	Lenses	Once per calendar year	\$200 allowance	Single Vision Lenses \$30 Lined Bifocal Lenses \$50 Lined Trifocal Lenses \$65 Lined	9/5/2025
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97 (cont'd)	<div style="display: flex; align-items: center; justify-content: space-between;"> <div style="flex: 1; background-color: #804000; height: 100px; width: 100px;"></div> <div style="flex: 1; background-color: #F0F0F0; height: 100px; width: 100px;"></div> <div style="flex: 1; background-color: #F0F0F0; height: 100px; width: 100px;"></div> <div style="flex: 1; background-color: #F0F0F0; height: 100px; width: 100px;"></div> </div> <p>Contact Lenses \$105 allowance (elective) \$210 allowance (Medically Necessary)</p> <p><i>*after deducting applicable Network Co-Payment amount</i></p>	9/5/2025																		
99	<p><i>Change removes per lens language.</i></p> <p><i>Article VII, Section 4(a) titled Schedule for Non-Network Doctor Charges on page 99 in the chart below is amended to read as follows:</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #804000; color: white;"> <th colspan="2">Reimbursement Allowances for Non-Network VSP Providers</th> </tr> <tr> <th>Service</th> <th>Reimbursement Allowance</th> </tr> </thead> <tbody> <tr> <td>Exams</td> <td><i>Up to \$45</i></td> </tr> <tr> <td>Frames</td> <td><i>Up to \$70</i></td> </tr> <tr> <td>Single Vision Lenses</td> <td><i>Up to \$30</i></td> </tr> <tr> <td>Lined Bifocal Lenses</td> <td><i>Up to \$50</i></td> </tr> <tr> <td>Lined Trifocal Lenses</td> <td><i>Up to \$65</i></td> </tr> <tr> <td>Elective Contact Lenses</td> <td><i>Up to \$105</i></td> </tr> <tr> <td>Medically Necessary Contact Lenses</td> <td><i>Up to \$210</i></td> </tr> </tbody> </table>	Reimbursement Allowances for Non-Network VSP Providers		Service	Reimbursement Allowance	Exams	<i>Up to \$45</i>	Frames	<i>Up to \$70</i>	Single Vision Lenses	<i>Up to \$30</i>	Lined Bifocal Lenses	<i>Up to \$50</i>	Lined Trifocal Lenses	<i>Up to \$65</i>	Elective Contact Lenses	<i>Up to \$105</i>	Medically Necessary Contact Lenses	<i>Up to \$210</i>	9/5/2025
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101	<p><i>Change creates the Paid Parental Leave Benefit for qualifying participants covered under the Health Plan.</i></p> <p>A new Article VIII, Paid Parental Leave Benefits is added as follows, and the existing Articles VIII through IX are renumbered accordingly:</p> <p style="text-align: center;">ARTICLE VIII. PAID PARENTAL LEAVE BENEFITS</p> <p>Section 1. Eligibility</p> <p>Effective July 1, 2025, you are eligible for a Paid Parental Leave (“PPL”) benefit if you have qualifying health coverage under the Health Plan, as described below, at the time of the birth of your child, date of adoption of a child, or the effective date of formally fostering a child. Although you must have qualifying health coverage under the Health Plan at the time of birth, adoption or fostering of a child, you do not have to maintain your health coverage throughout the leave period.</p> <p>For purposes of this Article VIII, adoption includes placement with you for adoption, and fostering of a child means that the child is placed with you by an authorized placement agency or a court order. In all cases, the child must be new to you. For example, if you adopt the child of your spouse who has already lived with you for an extended period of time, you are not eligible for the PPL benefit. In addition, you are not entitled to a second PPL benefit if you subsequently adopt a child you were fostering.</p>	7/1/2025																		

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101 (cont'd)	<p>The qualifying health coverage includes only Earned Coverage (<i>i.e.</i>, Earned Active, Earned Inactive or Regular Carry-Over), COBRA Continuation Coverage or Extended Self-Pay Coverage. Total Disability Extension or Retiree (<i>i.e.</i>, Retiree Carry-Over or Certified Retiree) Coverages are not qualifying health coverages. Additionally, at least some of the qualifying health coverage must have been earned from contributions made on your behalf by employers that are obligated to contribute for the PPL benefit during the applicable earnings period on either initial compensation or residual compensation.</p> <p>Notwithstanding the foregoing, individuals will be eligible for the PPL benefit if the qualifying health coverage on or after July 1, 2025 was based on an earnings period that began prior to July 1, 2024 for which no PPL contributions were required and included any initial compensation or residual compensation covered under the Basic Agreement or Freelance Live & Tape Television Agreement (FLTTA).</p> <p>You can only receive one PPL benefit in any 24-month period and the benefit must be taken within 12 months of the date of birth, adoption or fostering of a child. However, if both parents are participants with qualifying health coverage under the Health Plan, each parent is separately eligible for an individual PPL benefit, which can be taken concurrently or separately.</p> <p>Your dependents are not eligible to receive the PPL benefit should they have a child, adopt a child, or foster a child.</p> <p>Section 2. Applying for PPL Benefits</p> <p>The PPL benefit is intended as a partial replacement for income lost during a parental leave. Therefore, if you are eligible for a PPL benefit and wish to receive the benefit, you must not work for any employer during, or be paid by any employer for, the period for which the PPL is taken.</p> <p>To elect the PPL benefit, you must complete an application provided by the Health Plan office. As part of this application, you must sign an attestation that you will not perform work for any employer during, or be paid by any employer for, the period for which you are receiving, or will receive, the PPL benefit. You must also provide documentation to support the birth, adoption or fostering of a child.</p> <p>You must advise the Health Plan office immediately if, after applying for the PPL benefit, you decide to return to work during (or are going to be paid by any employer for) any portion of the period for which you applied for the PPL.</p> <p>Section 3. Benefit Duration and Amount</p> <p>After applying for the PPL benefit, including signing the required attestation, you will receive the following benefit:</p> <ol style="list-style-type: none"> 1. \$2,000 a week for a period of up to 8 weeks, for a total of up to \$16,000 if you have qualifying health coverage for Premier Choice coverage or DGA Gold Premier; or 	7/1/2025

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Pages	Summary of Change	Effective Date
101 (cont'd)	<p>2. \$1,200 a week for a period of up to 8 weeks, for a total up to \$9,600 if you have qualifying health coverage other than Premier Choice or DGA Gold Premier coverage.</p> <p>You may elect to take the weekly PPL benefit payments sequentially (<i>i.e.</i>, take all 8 weeks of PPL consecutively), or non-sequentially (<i>i.e.</i>, break them into separate weekly increments) not to exceed 8 weeks. The minimum increment is one 5-day work week beginning Monday and ending Friday. All requests for benefit payments must be prospective and will be paid only following approval of your PPL application by the Health Plan.</p> <p>You will receive the benefit payment on a weekly basis. The PPL benefit payments must be taken within 12 months from the date of birth, adoption or fostering of a child. Thus, you may not be paid beyond 12 months after the birth, adoption or fostering of a child.</p> <p>The PPL benefit provided hereunder will be coordinated with any income replacement benefit to which you may be entitled under local, state or federal law, subject to rules to be developed and adopted by the Health Plan Trustees. You must inform the Health Plan office of any local, state, or federal family leave benefit you are receiving or entitled to receive as a result of the birth, adoption of, or fostering of a child.</p> <p>After the 12 months have passed since the birth, adoption, or fostering of the child, you are no longer eligible to receive the PPL benefit, regardless of whether the full benefit amount has been used.</p> <p>Section 4. Claims and Appeals Rules</p> <p>The claims and appeals rules that apply to PPL benefits are generally the same rules that apply to claims and appeals for other benefits offered under the Health Plan, which are described in Article IX of this Summary Plan Description. Below is a summary of those rules as they apply to the PPL benefits.</p> <p>A claim is a request for the PPL benefit, made in accordance with the Health Plan's rules for filing such claim, which are described under Article IX, Section 2, <i>Filing a Claim</i>, of the Summary Plan Description. Filing an application for the PPL benefit, as described above, is a claim for the PPL benefit. A claim for PPL benefits is treated as a post-service claim under the Health Plan. Thus, all of the timing and notice requirements for a post-service claim apply to a claim for PPL benefits, except that if your claim is denied by the Health Plan office, you have 60 days from the date you receive the denial to file an appeal with the Benefits Committee. However, an external appeal to an IRO, as provided in Article IX, Section 4(l), <i>Independent Review Organization</i> below, is not available for PPL benefits.</p> <p>In addition, if you disagree with the Health Plan's determination regarding your eligibility for the PPL benefit in connection with a contribution audit, you must file a claim for the PPL benefit within 20 days of receiving notice of the</p>	7/1/2025

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101 (cont'd)	<p>contribution audit. To file a claim, you must send a letter, including any supporting documentation, to the Health Plan office explaining why you disagree with the contribution audit. You should mail your claim to: DGA-Producer Health Plan, Attn: Eligibility Department, 5055 Wilshire Blvd., Suite 600, Los Angeles, California 90036.</p> <p>You have certain rights to take legal action relating to a claim under the Health Plan for benefits. These rights are described in Article IX, Section 4(p), <i>Limitation on Legal Actions</i>.</p> <p>For more information about the claims and appeals rules that apply to the PPL benefit, or to request a copy of the Summary Plan Description, please contact the Health Plan office at (323) 866-2200, Ext. 401 or (877) 866-2200, Ext. 401. You may also view the Summary Plan Description at www.dgaplans.org.</p> <p>Section 5 Additional Terms</p> <p>The monies you receive through the PPL benefit do not count toward earning pension benefits or vesting credit, or toward eligibility for health coverage. Your eligibility for pension benefits and health coverage are determined independent of any PPL benefits you might receive.</p> <p>All PPL benefits are subject to the applicable tax deductions and withholdings.</p> <p>The PPL benefit is funded solely by the available funds in the separate account that holds the 0.5% of Employer contributions for the PPL benefit (plus any investment gains and minus any investment losses). No other Health Plan or Pension Plans assets can be used to fund the PPL benefit. If at any time the amount available in the PPL account is depleted, PPL benefits will not be available.</p> <p>More information (as well as an application for the PPL benefit) can be found at www.dgaplans.org/forms/paid-parental-leave. You can also request assistance by contacting the Health Plan office at (323) 866-2200, Ext. 401 or (877) 866-2200, Ext. 401.</p>	7/1/2025
101	<p><i>Change creates the Paid Parental Leave Benefit for qualifying participants covered under the Health Plan.</i></p> <p>Article IX (formerly Article VIII), Section 2, Filing a Claim is amended to add a new subsection (f) Paid Parental Leave Benefits Claims as follows:</p> <p>(f) Paid Parental Leave Benefits Claims</p> <p>You are responsible for submitting a claim for PPL benefits directly to the Health Plan office at: DGA-Producer Health Plan, Attn: Eligibility Department 5055 Wilshire Blvd., Suite 600, Los Angeles, California 90036.</p> <p>All claims must include the application, including signed attestation, applicable tax withholding forms and documentation of birth, adoption or fostering of the new child. Please see Article III, Section 5(b), <i>Verifying Eligible Dependents</i>, for a list of acceptable documents with respect to birth, adoption and</p>	7/1/2025

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101 (cont'd)	<p>guardianship. For purposes of providing documentation, fostering is treated like guardianship.</p> <p>The staff of the Health Plan office will either approve or deny your claim. If your claim is denied, in whole or in part, you or your authorized representative may file an appeal with the Benefits Committee, as described in Article IX, Section 4(g), <i>Filing an Internal Appeal</i>.</p>	7/1/2025

DGA PRODUCER
HEALTH PLAN



SUMMARY PLAN DESCRIPTION
HEALTH

Effective March 1, 2025

www.dgaplans.org

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How It Works:

How to Use this Book

This Summary Plan Description has been prepared to serve as a guide and reference concerning all aspects of your healthcare benefits and how to use them. This book has been organized to include certain features to help you find and understand the information contained herein. Refer to the graphic below for details.

Capitalized terms are defined in the Glossary, beginning on page 129.

Examples of concepts described in the text are set apart in greyed boxes.

Medical Benefits

per calendar year. Once each individual has met the \$325 deductible, the Health Plan will pay benefits on Covered Expenses, less any applicable Co-Payments or Co-Insurance for which the participant is responsible.

When you have coverage for yourself plus two or more dependents, the family Deductible is \$975. The Deductible works as follows:

- If one family member has \$325 of Covered Expenses in the calendar year, no further Deductible will be charged for that family member, leaving a remaining Deductible of \$650 for the rest of the family.
- The Plan will not apply more than the individual Deductible amount to any one family member; and if three or more covered family participants have a combined Deductible amount of \$975 in one calendar year, no further Deductibles will be charged to the family for that year.

(d) Co-Insurance

Co-Insurance is your share of the costs of a covered health care service at a percentage of the allowed amount for the service, once your Deductible has been met.

For example:

For Network benefits under the DGA Premier Choice and DGA Choice Plan, the Health Plan pays 90% of the Allowable Charge. Your Co-Insurance is 10%.

Once you satisfy the annual Deductible, the Health Plan shares covered charges with you, as shown in the chart below (4).

Co-Insurance Rates

Network		Non-Network			
The amounts below are applicable to Covered Expenses only.		DGA Premier Choice Plan	DGA Choice Plan	DGA Bronze Plan	DGA Premier Choice Plan
Plan Pays	90% of Allowable Charge for Covered Expenses*	90% of Allowable Charge	70% of Allowable Charge	70% of Reasonable and Customary for Covered Expenses*	50% of Reasonable and Customary for Covered Expenses*
Participant Pays	10% of Allowable Charge	10% of Allowable Charge	30% of Allowable Charge	30% of Reasonable and Customary for Covered Expenses*	50% of Reasonable and Customary for Covered Expenses*

* For Non-Network services, in addition to the Co-Insurance, you pay the difference between Reasonable and Customary Charge and the amount billed.

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Once your Deductible has been met and a covered service has been determined on your claim, you will be responsible for your portion of the Co-Insurance. If you use a Non-Network provider, you will be responsible for either the 30% or 40% (or 50% under the DGA Bronze Plan) of the remaining Covered Expenses based on the plan of coverage. As well as any amount above Reasonable and Customary Charges or amounts in excess of a specific plan benefit limit provided by either Network or Non-Network providers, including all non-Covered Expenses.

has a Reasonable and Customary Charge of \$2,500, the Plan will only pay Co-Insurance on the Reasonable and Customary amount for the Non-Network claim. Your Co-Insurance would be 30% of \$2,500, or \$750, and your Deductible would be \$2,250, and you would also be responsible for any amount exceeding the Reasonable and Customary Charge (\$7,500), making your total responsibility \$8,250.

On the other hand, if your claim is from a Network provider and their charge is \$2,500, and your Deductible is \$2,250, your Co-Insurance will be 10% (\$225) under either the Premier or Choice Plan. Any amount above the PPO contractual rate would be a cost savings to both you and the Health Plan. Network providers are not allowed to bill beyond the negotiated contractual rate.

Medical Benefits

How It Works: Allowable Charges, Deductibles & Co-Insurance

Joe's Diabetes Treatment

Joe has type 2 Diabetes—a well-controlled condition—and needs a visit to a routine Network care. The charts below show how his Deductible, Co-Payment, and Co-Insurance interact for the service incurred at a Network provider.

Joe's Charges		What Joe Pays	
Total Charge	\$5,400	Deductible*	\$325
Allowable Charge	\$5,000	Co-Insurance	\$267.50 (3000-125) x 10%
Joe's Deductible	\$325	Amount in excess of Allowable Charge	\$0
Joe's Network Co-Insurance	10%	Co-Payment	\$0
Joe's Co-Payment	\$0	Total Joe Pays	\$592.50

*The example above assumes Joe has not satisfied his annual Deductible.

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Each section is color-coded for easy browsing. A change in the sidebar color indicates a new section.

How it Works graphics describe critical processes and concepts.

INTRODUCTION

The Board of Trustees of the Directors Guild of America-Producer Health Plan (the “Health Plan” or “Plan”) is pleased to provide you with this Summary Plan Description describing the benefits currently offered under the Plan. This Summary Plan Description, together with the Directors Guild of America-Producer Health Trust Agreement (“Trust Agreement”), make up the Plan Documents for the Health Plan (as they may be amended from time to time). This Summary Plan Description is effective March 1, 2025, and replaces and supersedes all prior versions of the Summary Plan Description and amendments. Please discard any prior versions of the Summary Plan Description and amendments and refer to this current version on or after March 1, 2025 for information about the Health Plan.

The Health Plan is established and operated in accordance with the Employee Retirement Income Security Act of 1974, Internal Revenue Code (the “Code”), Section 302(c)(5) of the Labor Management Relations Act, and all other applicable federal and state laws, as amended from time to time. The Health Plan is also maintained in accordance with Collective Bargaining Agreements (“CBAs”) negotiated by the Directors Guild of America (“DGA”) and the Alliance of Motion Picture and Television Producers (“AMPTP”), the Association of Independent Commercial Producers (“AICP”), or other Employers in the entertainment industry. The Health Plan is a self-funded, self-administered, multiemployer plan whose assets are held in a trust in accordance with applicable law and CBAs. The Health Plan and Trust are separate and distinct entities from the DGA, the AMPTP, the AICP and other Employers.

This Summary Plan Description provides a brief description of your rights, obligations and benefits under the Health Plan. We prepared this Summary Plan Description to serve as a guide and reference concerning all aspects of your healthcare benefits and how to use them. We tried to keep this explanation of Health Plan benefits simple and easy to understand by using plain, straightforward language, but you may come across some unfamiliar terms not used in everyday conversation. That is because it is sometimes necessary to use certain specialized terms in order to be specific about your benefits. Other times, common terms may have special meanings when used in this Health Plan. We suggest that you familiarize yourself with the terms in the Glossary and in the *Health Plan Terms* section beginning on page 43.

When benefits are provided by insurance contracts or health maintenance organizations, the legal and policy terms of any group master contracts issued to the Health Plan will prevail and supersede any conflicting terms in this Summary Plan Description.

The Board of Trustees has the sole and exclusive authority to construe, apply and interpret the terms of the Health Plan and the nature and extent of benefits offered thereunder, including the rules governing eligibility for and entitlement to benefits. Health Plan employees 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 Board of Trustees to the extent inconsistent with the terms of the Plan and cannot enlarge or change such benefits and eligibility rules. The Board of Trustees is 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. The Board of Trustees also determines the Health Plan’s schedule of benefits and will rule on your appeals with respect to benefit denials regarding medical claims, including mental health and chemical

dependency claims. Questions regarding your rights under the Health Plan will be answered in accordance with the applicable Plan terms, legal requirements, and rules and regulations adopted by the Board of Trustees. Review of appeals regarding medical, Infertility, prescription, dental and vision claims will be ruled upon by providers of those services, as described in the section titled *Claims and Appeals Procedures* beginning on page 106.

The benefits described in this Summary Plan Description are not guaranteed or vested and may be modified, amended or terminated at any time by the Board of Trustees.

Assistant Director Trainees qualify for coverage based on the rules of the Assistant Director Training Program. If you are a Trainee, please contact the Assistant Director Training Program office for details.

If you have any questions about any terms or your coverage in general, please call the Health Plan office at **(323) 866-2200** or toll free outside the Los Angeles area at **(877) 866-2200**. You may also access the Health Plan Summary Plan Description and all updates at www.dgaplans.org.

Throughout this document, the terms “you” or “your” refer to the participant. Capitalized terms are defined in the Glossary that begins on page 129. If a capitalized term is not defined in the Glossary, it has the same meaning as defined in the Health Plan Summary Plan Description.

How You Are Notified of Health Plan Changes

Periodically, changes are made to the Health Plan by the Board of Trustees. You will be notified of any changes to the Health Plan through the Health Plan’s *Spotlight on Benefits* newsletter. You will be sent a copy of the *Spotlight on Benefits* newsletter any time the Health Plan is amended. Copies of the Health Plan Summary Plan Description and all amendments are also available online at www.dgaplans.org.

It is your responsibility to notify the Health Plan of any changes to your mailing address and contact information. Be sure to keep your contact information with the Plan current to ensure that you receive all communications. Please note you must notify the Health Plan separately of any changes to your address or contact information, even if you have already provided updated information to your Employer, the DGA or the US Postal Service.

ARTICLE I. SCHEDULE OF BENEFITS

This *Schedule of Benefits* summarizes the Health Plan benefits that are described in more detail in this Summary Plan Description.

Section 1. Medical Benefits

See the *Medical Benefits* section beginning on page 43.

	Network Provider	Non-Network Provider
Calendar Year Deductible	\$325 per person \$975 per family	\$325 per person \$975 per family
Percentage Payable by Health Plan	90% of Covered Expenses	<u>DGA Premier Choice Plan</u> 70% of Reasonable and Customary Allowed Amount for Covered Expenses <u>DGA Choice Plan</u> 60% of Reasonable and Customary Allowed Amount for Covered Expenses
Calendar Year Co-Insurance Maximum (in excess of Deductible)	\$1,000 per person	<u>DGA Premier Choice Plan</u> \$12,500 per person <u>DGA Choice Plan</u> \$20,000 per person
All-Inclusive Network Out-of-Pocket Limit	\$9,200 per person \$18,400 per family	None

Co-Payments and Network preventive care services do not count towards the calendar year Deductible. There is an All-Inclusive Network Out-of-Pocket Limit of \$9,200 per individual and \$18,400 per family. This limit includes all out-of-pocket costs for covered Network medical claims and prescriptions: Deductibles, Co-Payments and Co-Insurance. Non-covered benefits do not count towards the calendar year Deductible. For more information, please see the *Network Expenses* section beginning on page 48.

Dependent Premium Amounts

Enrollment	Annual Premium
Participant Only	No premium
Participant + 1 Dependent	\$780
Participant + 2 or more Dependents	\$1,200

Dependent premium payments must be paid on an annual or semi-annual basis and cannot be paid monthly. Required dependent premium payments will not be prorated for periods of coverage shorter than six months.

For more information, please see the section titled *Covering Dependents* beginning on page 30.

Visit and Benefit Amount Limitations

Certain benefits have a maximum Allowable Charge and visit limitations per calendar year. For example, Chiropractic Care is limited to 20 visits per individual per calendar year with an Allowable Charge of \$50 per visit when Medically Necessary. There are also various limitations on Acupuncture, nursing care, Physical Therapy and more.

Please refer to the section titled *What's Covered Under Medical Benefits* beginning on page 63 for examples of benefit-specific limitations.

Section 2. Prescription Drug Benefits

Please refer to the section titled *Prescription Drug Benefits* beginning on page 83 for more information about your prescription benefits.

	Co-Payment for Up to 30-day Supplies from Participating Retail Pharmacies	Co-Payment for Up to <u>90-day</u> Supplies from a CVS Pharmacy or CVS Caremark Mail Service Pharmacy (Maintenance Choice Program) ¹
Generic Drugs	\$10	\$25
Brand Name Drugs	\$24	\$60
Lifestyle Drugs ²	Greater of \$40 or 50% of the cost of the medication	Greater of \$60 or 50% of the cost of the medication

¹ The Plan allows patients to obtain up to two 30-day fills of their maintenance medication at any participating retail pharmacy. After these two fills are exhausted, patients must pay the full cost for their prescription unless they elect to receive their maintenance medication in a 90-day supply through a local CVS Caremark pharmacy or CVS Caremark Mail Service Pharmacy (Maintenance Choice). Acute medications may be filled at any participating retail pharmacy.

² Erectile dysfunction drugs, proton pump inhibitors, weight loss medications and sleep aids are covered under the Lifestyle Drug tier. In certain cases, these drugs require a coverage review. For more information, see section titled *Lifestyle Drugs* on page 86.

When you or your covered dependent choose to take a brand name drug when a generic equivalent is available, you or your covered dependent must pay for any cost difference between the brand name and generic drug, plus the generic Co-Payment amount. For more information, see the section titled *Brand vs. Generic: You Pay the Difference* beginning on page 86.

Prescriptions for maintenance medications that are taken on a long-term basis (three months or more) must be obtained through a local CVS Caremark pharmacy or CVS Caremark Mail Service Pharmacy (Maintenance Choice). For more information, see the *CVS Caremark Maintenance Choice for Long-Term Maintenance Medications* section beginning on page 84.

CVS Caremark Mail Service Pharmacy Co-Payments are the same, regardless of the supply filled. In other words, a 30-day prescription filled through CVS Caremark Mail Service Pharmacy will cost the same as a

90-day prescription filled through CVS Caremark Mail Service Pharmacy. In general, a 30-day prescription should be filled at a retail pharmacy. When the prescribed amount of a medication is restricted by law, the Health Plan will prorate the CVS Caremark Maintenance Choice Co-Payment based on the amount of the restricted medication prescribed.

Section 3. Dental Benefits

See the section titled *Dental Benefits* beginning on page 91.

	Network Dentists	Non-Network Dentists
Calendar Year Maximum	\$2,500 per person; does not apply to children under age 19	
Calendar Year Deductible	\$0	\$50/person; \$100/family
Co-Insurance (Category I)	100% of Covered Expenses	85% of Covered Expenses
Co-Insurance (Category II)	80% of Covered Expenses	60% of Covered Expenses
Co-Insurance (Category III)	70% of Covered Expenses	50% of Covered Expenses
Orthodontia	No Deductible; 50% of Covered Expenses; coverage only available for dependent children under age 19; lifetime maximum of \$1,500 per dependent child.	

Section 4. Vision Benefits

See the section titled *Vision Benefits* beginning on page 97.

	Service or Supply Frequency	Network Benefit	Non-Network Maximum Benefit*
Exams	Once per calendar year	\$30 Co-Payment	\$45 Co-Payment
Frames	Once every other calendar year	\$220 allowance; or \$240 allowance for featured frame brands	\$70 allowance
Lenses	Once per calendar year	\$200 allowance	Single vision lenses \$30 lined Bifocal lenses \$50 lined Trifocal lenses \$65 lined Contact lenses \$105 per lens per eye (elective) \$210 per lens per eye (Medically Necessary)

*after deducting applicable Network Co-Payment amount

ARTICLE II. PLAN AND BENEFIT PROVIDERS

The Health Plan

The Health Plan office is the primary point of contact for your questions regarding eligibility for benefits, enrollment, claims, premium payments and customer service.

Department	Questions Regarding	Contact Information
Health Plan Eligibility	■ Dependent Coverage ■ Open Enrollment ■ Qualifying for Coverage ■ Premium Payments	(323) 866-2200, Ext. 502 eligibility@dgaplans.org
Participant Services	■ Health Benefits ■ Health Claims	(323) 866-2200, Ext. 401 hpclaims@dgaplans.org

See below for the Health Plan's contact information:

DGA—Producer Health Plan
5055 Wilshire Blvd.
Suite 600
Los Angeles, California 90036

(323) 866-2200
(877) 866-2200 (toll-free)
www.dgaplans.org

Benefit Providers

The Health Plan also contracts with the benefit providers below and on the next page to manage certain aspects of Health Plan coverage and to provide specialized customer service, as applicable.

Benefit Provider	Phone Number	Web Address
Anthem Blue Cross To Find a Network provider	(800) 810-2583	www.anthem.com
Carrot	support@get-carrot.com* *You may email for questions or schedule a call after creating a Carrot account.	www.get-carrot.com
CVS Caremark CVS Specialty	(855) 271-6601 (800) 237-2767	www.caremark.com www.cvsspecialty.com
Delta Dental of California Benefits and Claims To Find a Network Dentist	(800) 846-7418 (800) 427-3237	www.deltadentalins.com
Motion Picture & Television Fund- Palliative Care	(818) 876-1739	www.mptf.com

Plan and Benefit Providers

Benefit Provider	Phone Number	Web Address
UCLA Health/EIMG	(800) 876-8320	www.uclahealth.org
VSP Vision	(800) 877-7195	www.vsp.com

Periodically, the Health Plan may add, drop or replace benefit providers. In order to obtain information regarding current benefit providers, please contact the Health Plan office or go to www.dgaplans.org.

ARTICLE III. ELIGIBILITY

The Health Plan provides comprehensive healthcare benefits for participants and their eligible dependents.

In general, you are eligible for Health Plan coverage if you meet one of the following criteria:

- have sufficient contributions paid to the Health Plan on your behalf on Covered Earnings (current or residuals);
- have sufficient Carry-Over Credits;
- are eligible for COBRA Continuation Coverage or Extended Self-Pay Coverage and pay the required premiums; or
- are eligible for Retiree Coverage and pay the required premiums.

No part of the benefits offered under the Health Plan are guaranteed. The Board of Trustees reserves the right to change, cancel or terminate the Health Plan, or any aspect of the Health Plan, at any time.

Section 1. Qualifying for Health Coverage

You will initially qualify for Health Plan coverage when you have sufficient contributions reported to the Health Plan on your behalf by an Employer for work you have performed in a DGA-represented capacity under a CBA requiring such contributions.

(a) Initial Eligibility

If you meet one of the following criteria, you will become eligible for Earned Coverage during a Benefit Period:

- you perform services covered under a DGA CBA and the Health Plan receives contributions on

your behalf on Covered Earnings at, or in excess of, the minimum earnings threshold during an Earnings Period; or

- you are a regular full-time employee of the Directors Guild of America or the DGA-Producer Pension and Health Plans. If you are such an employee, please refer to the Supplement for Non-Collectively Bargained Employees for eligibility and enrollment information.

If you qualify for Earned Coverage, your eligible dependents may also receive benefits. Please see the section titled *Covering Dependents* beginning on page 30 for more information.

(b) Earnings Periods

To qualify for Earned Coverage, the Health Plan must receive contributions on your behalf based on Covered Earnings equal to, or greater than, the applicable minimum earnings threshold during the corresponding 12-month Earnings Period.

Earnings Periods begin on January 1, April 1, July 1, and October 1 of each calendar year.

The minimum earnings threshold to obtain coverage under the DGA Choice Plan for all Earnings Periods that begin in 2025 is \$39,820*. The minimum earnings threshold to obtain coverage under the DGA Premier Choice Plan for all Earnings Periods that begin in 2025 is \$129,150*. Please see the section titled *DGA Premier Choice & DGA Choice Plans* beginning on page 49 for more information about the two plans.

***Important Information:** First, not all earnings are reportable to the Health Plan. Certain Collective Bargaining Agreements limit reportable earnings and residuals to an amount different from your

Eligibility

actual earnings and residuals, for example. Refer to the applicable Collective Bargaining Agreement (available at www.dga.org/Contracts/Agreements.aspx) that governs your project type and job category to verify the accuracy of earnings and residuals reported to the Health Plan on your behalf. Second, contributions must be paid to the Health Plan by your Employer on your Covered Earnings or reportable residuals to become eligible for coverage.



How It Works:

Earnings and Benefit Periods

For example:

If you earn \$39,820 in Covered Earnings during the January 1, 2025 to December 31, 2025 Earnings Period and the required contributions are paid by your Employer(s), your health coverage will become effective during the April 1, 2026 to March 31, 2027 Benefit Period (see the chart below (↓) for a more detailed illustration of how Earnings Periods work).

Earnings Periods extend for one year, beginning at the start of a calendar quarter. When you meet the Health Plan's minimum earnings threshold during an Earnings Period, there is a three-month waiting period. Then, you receive one year of Earned Active health coverage.

The chart below details the four 2025 Earnings and Benefit Periods.

2025												2026												2027											
January 2025	February 2025	March 2025	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026	April 2026	May 2026	June 2026	July 2026	August 2026	September 2026	October 2026	November 2026	December 2026	January 2027	February 2027	March 2027	April 2027	May 2027	June 2027	July 2027	August 2027	September 2027	October 2027	November 2027	December 2027
Earnings Period												Benefit Period																							
												Earnings Period												Benefit Period											
												Earnings Period												Benefit Period											
												Earnings Period												Benefit Period											

For example, using the chart above, if you met the minimum earnings threshold during the January 1, 2025 to December 1, 2025 Earnings Period, you will receive one year of health coverage during the April 1, 2026 to March 31, 2027 Benefit Period. There is a three-month waiting period from January 1, 2026 to March 31, 2026.

The minimum earnings threshold is reviewed by the Board of Trustees periodically and is subject to change at any time. You should always contact the Health Plan for the current minimum earnings threshold.

Your initial Earnings Period is the first four-quarter period that you meet the minimum earnings threshold. This will remain your applicable Earnings Period for as long as you qualify for Earned Coverage without a break. If you fail to qualify for Earned Coverage during your next Earnings Period, the Health Plan will roll forward your Earnings Period and look at the next four-quarter period to determine if you have subsequently qualified for Earned Coverage. For an example, refer to the graphic at the bottom of the page (↓).

Covered Earnings generated during an Earnings Period can only be applied towards that specific

Earnings Period's corresponding Benefit Period. Any contributions associated with Covered Earnings used to qualify you for Earned Coverage, in part or in full, cannot be used again.

(c) Benefit Periods

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 of each calendar year.

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 Earnings Period in which you qualify for Earned Coverage and the beginning of your corresponding Benefit Period.



How It Works:

How Your Earnings Period Is Established

If your earnings are...

	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec
2025	\$5,000	\$5,000	\$5,000	\$5,000
2026	\$30,000	\$5,000	\$10,000	\$5,000
2027	\$10,000	\$15,000	\$5,000	\$20,000

Then, the first four-quarter Earnings Period in which you would reach the minimum earnings threshold of \$39,820 is April 1, 2025 to March 31, 2026. This would qualify you for health coverage for the Benefit Period July 1, 2026 to June 30, 2027 and also establish April 1 to March 31 as your Earnings Period until you have a break in coverage.

During your next Earnings Period of April 1, 2026 to March 31, 2027, your earnings of \$30,000 fail to qualify you for Earned Coverage, thus causing your Earnings Period to roll forward until the next four-quarter period in which you meet the minimum earnings threshold, which would be July 2026 to June 2027, entitling you to coverage for the Benefit Period October 2027 to September 2028.

For example:

If you earn \$39,820 during the April 1, 2025 to March 31, 2026 Earnings Period, your health coverage will be in effect during the July 1, 2026 to June 30, 2027 Benefit Period (see the chart on page 8 for a more detailed illustration of how Benefit Periods work).

There is no exception to the three-month waiting period.

Once your coverage begins, it remains in effect for one Benefit Period (*i.e.*, 12 months). You cannot qualify for more than one Benefit Period at a time. A Benefit Period must be used in full before a new Benefit Period can begin.

The chart on page 8 of this Summary Plan Description illustrates the four 2025 Earnings Periods and their corresponding Benefit Periods.

(d) Active vs. Inactive Coverage

If contributions have been received based on the minimum earnings threshold for Covered Earnings from current work with a signatory Employer, you will be covered under Earned Active Coverage.

If you are on Carry-Over Coverage, you will be covered under Earned Inactive Coverage.

If contributions on Covered Earnings have been received based on the minimum earnings threshold only after taking into account contributions related to income from residuals, you will be covered under Earned Inactive Coverage.

For example:

If the minimum earnings threshold for DGA Choice Plan coverage is \$39,820 and you have \$20,000 in non-residual Covered Earnings plus \$20,000 in residual Covered Earnings, you will be covered under Earned

Inactive Coverage. This is because you did not meet the minimum earnings threshold based solely on your non-residual earnings.

This distinction between Earned Active Coverage and Earned Inactive Coverage affects how the Health Plan coordinates benefits with Medicare or any other insurance carrier. For additional information, please refer to the section titled *Coordination of Benefits* beginning on page 54.

(e) Contributions

The Health Plan is funded by Employer contributions. The applicable contribution rates are negotiated pursuant to Collective Bargaining Agreements between the Directors Guild of America and Employers.

Earned Coverage under the Health Plan can only be acquired through contributions paid on Covered Earnings on your behalf by an Employer. Individual participants cannot pay contributions on their own behalf to qualify for Health Plan coverage.

Contributions must be received in order for eligibility to be granted. Your coverage is based on contributions on Covered Earnings received by the Health Plan, not the compensation that is paid to you by an Employer. However, for convenience, earnings equivalents are sometimes used in this booklet.

For purposes of determining when benefits are earned, earnings and contributions are generally recognized by the Health Plan when the work is performed, regardless of when contributions are actually received by the Health Plan or when you receive compensation. Contributions based on residuals are recognized by the Health Plan on the exhibition date, or for prepaid residuals, the work period. Notwithstanding the foregoing, any contributions on compensation paid to a Director covered under the Basic or Freelance Live and Tape Television Agreements for an Earnings Period for which the Director was scheduled to commence

working between March 1, 2020 and ending December 31, 2020, shall be recognized in the Earnings Period in which the Director would have commenced work, but for the fact that production was delayed due to the coronavirus pandemic.

Once the Health Plan receives contributions on your behalf based on sufficient Covered Earnings to qualify for Earned Coverage during an Earnings Period, the coverage you receive for that Earnings Period will last for 12 months beginning with the next Benefit Period. Any Covered Earnings generated after that Earnings Period will be applied to your next 12-month Earnings Period. Unless there is an adjustment to reported contributions, you cannot switch from the DGA Choice Plan to the DGA Premier Choice Plan, or vice versa, in the same Benefit Period.

For example:

If you initially generate Covered Earnings of \$40,000 in June 2025, your Earnings Period for Health Plan eligibility purposes will be July 1, 2024 through June 30, 2025. You would then qualify for Earned Coverage in the DGA Choice Plan during the October 1, 2025 to September 30, 2026 Benefit Period.

If you subsequently generate additional Covered Earnings equal to or more than \$129,150 in July 2025, those earnings would apply to the July 1, 2025 through June 30, 2026 Earnings Period. As a result, you would be covered under the DGA Premier Choice Plan during the October 1, 2026 to September 30, 2027 Benefit Period.

(f) Adjustments to Reported Contributions

Each quarter, the DGA–Producer Pension and Health Plans (collectively, the “Plans”) will mail you a statement detailing the contributions reported and remitted to the Plans on your behalf. When

you receive your statement, please review it for accuracy and contact the Plans immediately to correct any errors.

We strongly urge you to keep detailed records of your Covered Earnings and work performed in a DGA-represented capacity and to report any discrepancies to the Plans. If contributions are overreported on your behalf and you consequently become eligible for Health Plan coverage that you otherwise would not have been eligible for, your coverage could be cancelled. If you perform an act, engage in a practice or commit an omission which constitutes fraud or an intentional misrepresentation of material fact for the purpose of obtaining coverage under the Health Plan for yourself or your dependent(s), you will be responsible for any overpaid benefits. On the other hand, if contributions are underreported on your behalf, you may not receive all of the benefits for which you would have been eligible.

If there is an adjustment that reduces the amount of your acceptable contributions (as a result of an audit or otherwise), you will be given 30 days advance written notice of any retroactive change, and the reporting company may be held responsible for any benefits that were paid on your behalf that would not have been paid had the contributions been properly reported. If you, or someone acting on your behalf, commits a fraudulent act or omission, or makes an intentional misrepresentation of fact to assist in the improper payment or reporting of contributions on your behalf, you and the reporting company will be responsible for reimbursing the Health Plan for any benefits incorrectly paid based on such acts, omission or incorrect information, and during any periods that you and/or any dependents should not have been covered under the Health Plan, or during any periods that you and/or any dependents should have been covered under a different plan of benefits (e.g., if you or your dependent should have been covered under the DGA Choice Plan, not the DGA Premier Choice Plan).

If there is an adjustment that increases the amount of your acceptable contributions (as a result of an audit, late contributions received or otherwise), you will be eligible to receive benefits that you would have been eligible for had the contributions been properly reported in a timely manner. You will be eligible for those benefits based on the Earnings Period during which the Covered Earnings were originally earned, not when the adjustment was made.

For example:

If contributions are underreported on your behalf for Covered Earnings earned in July 2025, and the underreporting of contributions is discovered in July 2027, the underreported contributions, when paid, will still be credited to July 2025, not July 2027.

If additional contributions result in health coverage that was not previously earned or upgraded coverage from the DGA Choice Plan to the DGA Premier Choice Plan, you may submit any additional health claims to the Health Plan that were not previously submitted during the corresponding Benefit Period. In addition, the claims previously submitted on your behalf for that Earnings Period will automatically be readjudicated by the Health Plan, taking into account the new level of coverage.

There is a three-year period from the date contributions are received during which the Health Plan will consider adjustments or late contributions for eligibility purposes. This period will be extended if the late contributions are received as a result of an audit by the amount of time taken by the Plans to complete the audit.

While contributions received after the applicable time limit will not be considered for the purpose of granting eligibility, you will receive credit for any Earned Coverage years and applicable Carry-Over Credit that results from the late contributions. This

may affect your eligibility for Carry-Over Coverage, COBRA Continuation Coverage, Extended Self-Pay Coverage and Retiree Coverage.

In some cases, adjustments that reduce or increase the amount of your acceptable contributions may alter your eligibility cycle to obtain benefits. This may result in a loss of coverage. The reporting company may be held responsible for benefits that were paid when a loss of coverage results from the shift in coverage periods, if permissible under applicable law.

If an audit determines that an Employer misreported contributions on your behalf, which results in the loss of coverage under the Health Plan, the Employer must pay for either any overpaid health claims for you and any dependents or the cost of what the COBRA premiums would have been for you and any dependents during any periods you should not have been covered under the Health Plan.

Section 2. Maintaining Your Earned Coverage

Once you establish your initial eligibility for benefits, you can maintain your Earned Coverage in one of two ways:

- continue to generate contributions on Covered Earnings equal to or greater than the minimum earnings threshold; or
- use available Carry-Over Credit.

(a) Carry-Over Credit

With sufficient contributions, you can accumulate Carry-Over Credit that can be used to qualify for health coverage in a future Earnings Period in which your Covered Earnings are below the minimum earnings requirement for Earned Coverage. When you have Covered Earnings during an Earnings Period in excess of the Carry-Over Threshold, you earn Carry-Over Credit as follows:

- the threshold after which Covered Earnings will be credited is \$160,000. There is no maximum amount of Covered Earnings that can be credited in any year (subject to the overall maximum balance in an individual's Carry-Over Account as described below); and
- the overall maximum balance of Covered Earnings permitted in an individual's Carry-Over Account is \$510,000.

If you do not meet the minimum earnings requirement for Earned Coverage during an Earnings Period and you have sufficient Carry-Over Credit in your account, the Health Plan will automatically deduct \$160,000 in earnings from your Carry-Over Account to qualify you for 12 months of Health Plan coverage. Then, if necessary, an additional \$160,000 in earnings will automatically be deducted for a second year of coverage, etc. The full \$160,000 will be deducted regardless of how close you are to meeting the minimum earnings requirement.

Effective with Benefit Periods beginning on or after October 1, 2021, \$510,000 in earnings is the maximum Carry-Over Account balance.

The earnings threshold, the amount of Carry-Over Credit required for 12 months of Health Plan coverage, and the maximum account balance are subject to change.

For example:

Let's say \$160,000 in Covered Earnings is banked in your Carry-Over Account in 2025. Then, five years later, in 2030, you do not have sufficient Covered Earnings for Earned Coverage. However, \$170,000 in Carry-Over Credit may be needed for 12 months of Health Plan coverage in 2030. You would then need to have banked an additional \$10,000 in Covered Earnings in your Carry-Over 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 Extended Self-Pay Coverage in the same manner as Earned Coverage. For more information, refer to the sections titled *Certified Retiree Coverage* beginning on page 25 and *Extended Self-Pay Coverage* beginning on page 22.

Whenever Carry-Over Credit is used for Health Plan coverage, the coverage is considered Earned Inactive Coverage for coordination of benefits purposes (see section titled *Coordination of Benefits* beginning on page 54). If you or your eligible dependents are covered under Medicare, the Health Plan will pay benefits secondary to Medicare if you are on Carry-Over Coverage (see the section titled *Coordination of Benefits with Medicare* beginning on page 59).

If you qualified for health coverage through Carry-Over Credit, you will be covered under the DGA Premier Choice Plan (see the section titled *DGA Premier Choice & DGA Choice Plans* beginning on page 49).

A full year of Carry-Over Credit is used at the time that you start Carry-Over Coverage, providing coverage for a period of 12 months. You cannot use Carry-Over Credit for less than one year of coverage. If, during this 12-month period, you meet the criteria for Earned Active Coverage or Earned Inactive Coverage, the ongoing Carry-Over Coverage remains in effect until it is scheduled to end.

Furthermore, Carry-Over Credit cannot be used to supplement self-pay premiums or Employer health contributions. Coverage through Carry-Over Credit cannot be delayed to a later date, and a balance in Carry-Over Credit cannot be used to supplement a shortage in earnings to qualify for benefits or to supplement coverage in order to be in a higher level of coverage. For example, if your earnings qualify you for the DGA Choice Plan, you cannot use your remaining balance of Carry-Over Credit to

supplement a shortage in earnings to qualify for the DGA Premier Choice Plan.

Section 3. Making Changes to Your Health Coverage

Periodically, you can make certain changes to your health coverage, such as adding or dropping dependents or changing self-pay options. Generally, these changes must be made during your Open Enrollment Period.

Your applicable Open Enrollment Period is based on the type of coverage that you have:

- If you are on Earned Coverage, the Open Enrollment Period is the first 30 days of your Benefit Period.
- If you are on COBRA Continuation Coverage, Extended Self-Pay Coverage or Retiree Coverage, the 30-day Open Enrollment Period begins on the yearly anniversary of that coverage.

For example:

If you started COBRA Continuation Coverage on August 15, 2025, your Open Enrollment Period would be the 30-day period beginning every August 15 of each year.

If you received retroactive coverage as a result of late contributions, the 30-day Open Enrollment Period will begin on the date you are notified by the Health Plan that you have qualified for Health Plan coverage.

Changes made during your Open Enrollment Period are effective for the entire 12-month Benefit Period.

Section 4. When Your Earned Coverage Ends

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 Earnings Period; or
- the date that the coverage for which you are eligible is eliminated from the Health Plan.

Earned Coverage for your eligible dependents will stop 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;
- the date the dependent ceases to meet the definition of an eligible dependent (see the *Eligible Dependents* section beginning on page 30);
- 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 timely.

When your Earned Coverage has been exhausted, you may be eligible to continue coverage on a self-pay basis with COBRA Continuation Coverage. You may also be eligible for other types of self-pay coverage that will extend beyond the COBRA Continuation Coverage period.

It is important to note that all self-pay coverage is considered Inactive Coverage. If you qualify for additional coverage elsewhere—including through Medicare, your Employer or another entertainment industry plan—electing a type of Inactive Coverage may affect how your benefits are coordinated between your plans. Refer to the section titled

Types of Self-Pay Coverage

	COBRA Continuation Coverage	Extended Self- Pay Coverage	Retiree Coverage	
			Retiree Carry- Over Coverage	Certified Retiree Coverage
Eligibility Requirements	Loss of Earned Coverage based on certain qualifying events	<ul style="list-style-type: none"> ■ Must have completed 18 months of COBRA Continuation Coverage ■ Must have completed at least 10 years of Earned Coverage 	<ul style="list-style-type: none"> ■ Have earned at least one Retiree Carry-Over Credit ■ Have at least 20 years of Earned Coverage ■ Be at least 65 years old ■ Have retired from either the DGA-Producer Basic Pension Plan or the DGA-Producer Supplemental Pension Plan 	<ul style="list-style-type: none"> ■ Be at least 60 years old ■ Have at least 20 years of Earned Coverage ■ Have retired from either the DGA-Producer Basic Pension Plan or the DGA-Producer Supplemental Pension Plan
When Coverage is Offered	Determined by qualifying events (next page)	Immediately after completing 18 months of COBRA Continuation Coverage	When all requirements have been met and all Earned Coverage has been exhausted	When all requirements have been met and all Earned Coverage has been exhausted
Maximum Duration of Coverage	18 or 36 months (dependent on qualifying event)	60 months (including COBRA Continuation Period)	Dependent upon the number of Retiree Carry-Over Credits earned and timely payment of premiums	<p>Coverage continues until:</p> <ul style="list-style-type: none"> ■ you do not pay your premiums on time; or ■ in the case of Social Security disability, 30 days after the month in which the Social Security Administration determines that you are no longer totally disabled.

Eligibility

Coordination of Benefits beginning on page 54 for more information.

The types of self-pay coverage are summarized in the chart on the previous page.

(a) 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 (known as “qualified beneficiaries”) on a self-pay basis, if you or your eligible dependents lose coverage based on certain qualifying events, which are detailed more in this section.

(1) What is COBRA Continuation Coverage?

Under COBRA, you are eligible to self-pay for Health Plan coverage for you and/or your eligible dependents for a period of time that is determined by the applicable qualifying event(s). The qualifying events are summarized in the chart below (↓), along with the duration of continuation coverage

available as a result of each qualifying event. A more complete description of these benefits follows the chart.

The Health Plan determines what constitutes a qualifying event in accordance with all applicable laws. If you have questions about what constitutes a qualifying event, please contact the Health Plan for more information.

There may be other coverage options available when you or covered dependents lose group health coverage.

THROUGH THE HEALTH INSURANCE MARKETPLACE

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you and your covered dependents may be able to obtain coverage at a lower cost, including reduced monthly premiums and out-of-pocket costs.

COBRA Continuation Coverage Qualifying Events		
Qualifying Event	COBRA Continuation Coverage May Continue for	Maximum Duration of COBRA Continuation Coverage
Your Earned Coverage terminates because you do not meet the minimum Covered Earnings requirement for a Benefit Period due to loss of employment, reduction in hours, or for any other reason	You and eligible dependents	18 months (29 months for the disabled person if you or one of your eligible dependents is disabled at the time of the qualifying event or becomes disabled within 60 days of the qualifying event*)
You die	Your dependents	36 months
You divorce your spouse who was a covered dependent	Your former spouse, your former stepchildren (if any)	36 months
Your dependent children cease to qualify as eligible dependents	Your dependent children	36 months

* Please see the section titled *COBRA Continuation Period* beginning on page 18 for information on the requirements for obtaining an extension of COBRA Continuation Coverage because of disability.

THROUGH ANOTHER GROUP HEALTH PLAN OR YOUR SPOUSE'S EMPLOYER-SPONSORED PLAN

Additionally, you may qualify for a 30-day Special Enrollment Period for another group health plan for which you are eligible (such as a spouse's plan).

(2) Is my spouse or dependent eligible for COBRA Continuation Coverage?

Your spouse and eligible dependents may qualify for the following periods of COBRA Continuation Coverage based on the corresponding qualifying event:

- Termination of coverage due to termination of employment: 18 months
- Termination of coverage due to reduction in hours/earnings: 18 months
- Termination of coverage due to retirement of participant: 18 months
- Termination of coverage due to divorce from a spouse: 36 months
- Termination of coverage due to loss of dependent status: 36 months
- Termination of coverage due to death of participant: 36 months
- Termination of coverage due to Medicare eligibility: 36 months

It is your responsibility to inform the Health Plan office if you have divorced your spouse. Notification must be made within 60 days of the date your divorce is finalized so the Health Plan can make any necessary updates to the eligibility information for you and your former spouse. Both you and your former spouse may be held responsible for any benefits that were paid on behalf of your former spouse after they no longer qualify as your eligible dependent. For more information, refer to the section titled *Overpayments* beginning on page 115.

All provisions of COBRA Continuation Coverage as outlined below will apply.

COBRA CONTINUATION COVERAGE IN ANTICIPATION OF A DIVORCE

Please note that you may be prohibited under the applicable laws in your state and/or jurisdiction from dropping your spouse from your Health Plan coverage while your divorce proceedings are still pending. If you remove your spouse from your Health Plan coverage during your divorce proceedings in violation of applicable law or court order, you will not be permitted to add your spouse back onto the Health Plan as your dependent outside of open enrollment. Please check with your attorney for more information regarding your obligations to cover your spouse while your divorce proceedings are pending.

If you eliminate coverage for your spouse in anticipation of divorce and a divorce later occurs, the later divorce may be considered a qualifying event for your ex-spouse, even though he or she is not covered under the Plan on the date of the divorce. In order for the divorce to be considered a qualifying event, however, your ex-spouse must notify the Health Plan within 60 days from the date the divorce is finalized. Once your ex-spouse's COBRA election is processed by the Health Plan, the duration of COBRA Continuation Coverage is for a 36-month period measured from the date the divorce is finalized.

(3) When is COBRA Continuation Coverage Available (Qualifying Events)?

COBRA Continuation Coverage starts the day after you lose Earned Coverage under the Health Plan due to a qualifying event. The Health Plan will automatically offer COBRA Continuation Coverage to qualified beneficiaries after the Health Plan office has determined that the qualifying event has occurred in connection with the following events:

- the termination of your Earned Coverage as a result of failing to meet the minimum earnings requirement;
- loss of employment;
- reduction in coverage type (*i.e.*, DGA Premier Choice Plan to DGA Choice Plan coverage); or
- your death.

You must notify the Health Plan office within 60 days after the qualifying event occurs in connection with the following events:

- divorce of the employee and spouse;
- a dependent child's loss of eligibility for coverage as a dependent child; or
- the death of the participant (if you are a covered dependent).

You must provide this notice of a qualifying event in writing to the Health Plan's Eligibility Department at:

DGA-Producer Health Plan
Attn: Eligibility Department
5055 Wilshire Blvd.
Suite 600
Los Angeles, California 90036
Fax: (323) 866-2399
Email: eligibility@dgaplans.org

Your written notice must include all of the following information:

- the names of the participant, participant's spouse and any dependents covered under the Health Plan;
- the type of qualifying event that has occurred; and
- the date of the qualifying event.

If you or your dependents do not notify the Health Plan office of your qualifying event in writing with

all the required information within 60 days of its occurrence, you and your dependents will forfeit your rights to enroll in any of the Health Plan's continuation coverage programs, and you and your dependents will be responsible for reimbursing the Health Plan for any benefits paid on behalf of you or your dependents after they ceased to be eligible dependents.

You must also notify the Health Plan office within 60 days of the qualifying event if you are adding a dependent to, or dropping a dependent from, your COBRA Continuation Coverage.

(4) COBRA Continuation Period

The maximum duration of COBRA Continuation Coverage due to the death of a participant, divorce or loss of dependent status is 36 months.

The maximum duration of COBRA Continuation Coverage due to a termination of your Earned Coverage is 18 months. However, this 18-month period may be extended for your spouse and dependent children to 36 months from the loss of coverage (the "termination date") if a second qualifying event such as your death, divorce or child's loss of dependent status occurs during the 18-month period. To receive this extension, you or a family member must notify the Health Plan office within 60 days of the second qualifying event.

If you become entitled to Medicare before your termination, your spouse and dependent children, if any, may elect continuation coverage for up to the greater of:

- 18 months from the termination date; or
- 36 months from the date of your Medicare entitlement.

If you become entitled to Medicare after your termination, your spouse and dependent children, if any, may elect COBRA Continuation Coverage for an additional 18 months, for a total of 36 months of continuation coverage from the termination date.

In no event will COBRA Continuation Coverage last beyond 36 months from the termination date.

Your initial 18 months of COBRA Continuation Coverage may be extended to 29 months total, if the Social Security Administration determines you 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 later of the Social Security Administration's determination or the loss of Earned Coverage. The Health Plan office must also receive this notice within the initial 18-month COBRA continuation period. Notwithstanding the foregoing, the 11-month extension will terminate immediately upon a determination by the Social Security Administration that the disabled individual is no longer disabled. Federal law requires you to inform the Health Plan office of any final determination that the disabled individual is no longer disabled within 30 days of such determination.

The Health Plan office will notify you of your right to elect COBRA Continuation Coverage within 60 days of determining that a qualifying event has occurred (in the event of your death or the termination of your Earned Coverage) or of being notified that a qualifying event has occurred (e.g., in the event of death, divorce or loss of dependent status). When the Health Plan office notifies you of your right to elect COBRA Continuation Coverage, you will have 60 days from 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 timeframe, your coverage will terminate.

NOTICE OF UNAVAILABILITY OF COBRA CONTINUATION COVERAGE

In the event the Plan is notified of a qualifying event but determines that you are not entitled to the requested COBRA Continuation Coverage, the Health Plan will send you an explanation indicating why COBRA Continuation Coverage is not available. This notice will be sent according to the same timeframe as a COBRA election notice.

EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

Your COBRA Coverage period will terminate early under any one of the following circumstances:

- you begin Earned Coverage;
- you do not pay your premiums on time (see the section titled *COBRA Premium Payments* beginning on page 21 for a description of when premiums are due);
- the Health Plan no longer provides group healthcare coverage;
- during an extension of the maximum COBRA Coverage period to 29 months due to the disability of the qualified beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled; or
- if a qualified beneficiary engages in fraud or other conduct that would justify terminating coverage of a similarly situated participant or beneficiary not receiving COBRA Continuation Coverage.

NOTICE OF EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

The Plan will notify a qualified beneficiary if COBRA Continuation Coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual

to COBRA Continuation Coverage. This written notice will explain the reason COBRA Continuation Coverage terminated earlier than the maximum period, the date COBRA Continuation Coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Health Plan determines that COBRA Continuation Coverage will terminate early.

Once COBRA Continuation Coverage terminates early, it cannot be reinstated.

(5) How is COBRA Continuation Coverage provided?

If the Health Plan office determines that a qualifying event has occurred or receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage (*i.e.*, you, your spouse or dependent children may elect single coverage and not include other family members who choose not to continue coverage) during the 60-day COBRA election period. You or your spouse may elect COBRA Continuation Coverage on behalf of any qualified beneficiaries.

Parents or legal guardians may elect COBRA Continuation Coverage on behalf of their children under age 18.

If your spouse or dependent children elect COBRA Continuation Coverage, they are not eligible to elect the Certified Retiree or Retiree Carry-Over options described in the *Retiree Coverage* section beginning on page 23 (unless he or she is your surviving spouse). Additionally, their coverage is limited to the maximum COBRA Continuation Coverage period rather than your self-pay continuation period.

A child who is born to you, adopted by you, placed for adoption with you, or that becomes your stepchild by marriage, and who is covered with you during the COBRA continuation period will

be eligible to become a qualified beneficiary who is 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 Continuation Coverage upon proper and timely notification to the Health Plan office of the birth, adoption, marriage or placement for adoption. A child added during the COBRA continuation period will continue to be covered only for the period of time that you are covered, subject to continuation of that coverage under the continuation rules discussed in the *COBRA Continuation Period* section beginning on page 18.

(6) COBRA Continuation Coverage Plan Options

If you were covered under the DGA Choice Plan or the DGA Premier Choice Plan immediately prior to your qualifying event 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 in the *Self-Pay Plans at a Glance* section beginning on page 26 and include the DGA Gold Plan, DGA Silver Plan and DGA Bronze Plan. Qualified beneficiaries may also elect a lower coverage option than they were covered under immediately prior to the qualifying event. Once you or your dependents choose to continue coverage under one of these coverage options, you or your dependents cannot later elect to be covered under a higher coverage option.

Also, if you choose not to continue coverage for your dependents, their coverage cannot be reinstated immediately (although they may individually elect COBRA Continuation Coverage during the 60-day COBRA election period). You must wait until the next Open Enrollment Period, Special

Enrollment Event, or you must requalify for Earned Coverage through Employer contributions to have any dropped coverage for dependents reinstated.

(7) COBRA 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.

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.

If payment is not received prior to the end of your 30 or 45-day grace period, your coverage will be terminated. Once coverage is terminated, coverage cannot be reinstated on a self-pay basis.

If you pay the premium in advance and the rate subsequently changes, you will be responsible for any additional amount due.

(8) If You Have Questions

Questions concerning your Health Plan or your COBRA Continuation Coverage rights should be addressed to the Health Plan's Eligibility Department at the following:

DGA-Producer Health Plan
Attn: Eligibility Department
5055 Wilshire Blvd.
Suite 600
Los Angeles, California 90036
Email: eligibility@dgaplans.org

Or using the information in the chart at the bottom of the page (↓):

For more information about your rights under ERISA, COBRA, HIPAA, the No Surprises Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

(9) Keep the Health Plan Informed of Changes to Your Address and Contact Information

You are obligated to keep the Health Plan office informed of any changes to your contact information, including your address, telephone number, email address, and the addresses and telephone numbers of family members and dependents. Please note that you must separately notify the Health Plan office of any updates to your contact information, even if you have already notified your Employer, the DGA or the US Postal Service. If the Health Plan office does not have current contact information for you and your family, you could miss important information about your benefits and your right to COBRA Continuation Coverage could be jeopardized. You should also

For Questions about the Health Plan

Department to Contact	For Questions Regarding	Contact Information
Health Plan Eligibility	<ul style="list-style-type: none"> ■ Dependent Coverage ■ Open Enrollment ■ Qualifying for Coverage ■ Premium Payments 	Tel: (323) 866-2200, Ext. 502 Toll Free: (877) 866-2200, Ext. 502 Fax: (323) 866-2399 eligibility@dgaplans.org

To Update Your Contact Information		
Department to Contact	For Questions Regarding	Contact Information
Demographics	All Address Change requests (including email updates)	Tel: (323) 866-2200, Ext. 407 Toll Free: (877) 866-2200, Ext. 407 Fax: (323) 866-2389 Email: demographics@dgaplays.org

keep a copy, for your records, of any notices you send to the Health Plan office.

You can update your address and contact information via either of the following:

- if you are a registered user of the myPHP benefits web portal, you can submit your updated information by logging in at www.dgaplays.org/myphp and navigating to My Profile; or
- you can download a Change of Address form at www.dgaplays.org/forms and send a completed copy to the Health Plan at the mailing address, fax or email noted on the form.

Please contact the Health Plan's Demographics Department using the information in the chart above (↑) if you have any questions.

(b) Extended Self-Pay Coverage

If you have completed at least 10 years of Earned Coverage, you may self-pay for five total years of health coverage immediately upon losing Earned Coverage between COBRA Continuation Coverage and Extended Self-Pay Coverage. Extended Self-Pay Coverage starts the day after COBRA Continuation Coverage ends (typically 18 months) and lasts up to an additional 42 months. This means that instead of self-paying for only 18 months under COBRA Continuation Coverage, you may also self-pay for an additional 42 months. This additional 42 months is referred to as Extended Self-Pay Coverage.

If you return to work and have sufficient Covered Earnings to requalify for Earned Coverage, you may be entitled to self-pay for another 60 months of health coverage if you later lose Earned Coverage.

Extended Self-Pay Coverage runs concurrently with the COBRA continuation period. In other words, the 60 months of self-pay referenced in this section includes the COBRA continuation period.

When transitioning from COBRA Continuation Coverage to Extended Self-Pay Coverage, you cannot elect a different self-pay plan until your next Open Enrollment Period.

The premiums for Extended Self-Pay Coverage beyond the initial COBRA continuation period, and for periods when you are on a COBRA disability extension, are higher than those during the COBRA continuation period. Assuming your COBRA Continuation Coverage period lasts 18 months, this means that your self-pay premium will increase beginning on your 19th month of self-pay coverage.

Your Extended Self-Pay Coverage period will terminate early under the following circumstances:

- you begin Earned Coverage;
- you do not pay your premiums on time (see the section titled *Self-Pay Premiums* beginning on page 28 for more information on when premiums are due); or
- the Health Plan no longer provides group healthcare coverage.

(c) Retiree Coverage

You may be eligible to self-pay for healthcare coverage as a retiree. There are two types of self-pay Retiree Coverage:

- Retiree Carry-Over Coverage
- Certified Retiree Coverage

All Retiree Coverage runs concurrently with the COBRA continuation period. If you elect Retiree Coverage and later decide to terminate that coverage or your coverage is terminated due to non-payment of premiums, you will not be eligible to continue your Health Plan coverage through COBRA Continuation Coverage.

(1) Retiree Carry-Over Coverage

You may use Retiree Carry-Over Credits to extend your coverage after you have retired and have exhausted your Earned Coverage.

Effective for Earnings Periods beginning on or after January 1, 2009, you will receive one Retiree Carry-Over Credit for each Earnings Period where you have at least \$375,000 in reported Covered Earnings. You may not receive more than one Retiree Carry-Over Credit per Earnings Period. Retiree Carry-Over Credits that were earned in previous eligibility periods remain unchanged.

Effective on and after January 1, 2025, Retiree Carry-Over Credits can only be used if you:

- have at least 20 years of Earned Coverage;
- are at least age 65 (this requirement is not waived if you are determined to be totally disabled); and
- are currently receiving (or have received) a pension benefit from either the DGA Basic Benefit Plan (the “Basic Plan”) or DGA Supplemental Benefit Plan (the “Supplemental Plan”).

Prior to January 1, 2025, Retiree Carry-Over Credits can only be used if you:

- have at least 10 years of Earned Coverage;
- are at least age 65 (this requirement is not waived if you are determined to be totally disabled); and
- are currently receiving (or have received) a benefit from either the DGA Basic or Supplemental Benefit Plans.

Notwithstanding the foregoing, any participants who: (1) have between 10 and 20 years of Earned Coverage on January 1, 2025; and (2) previously elected Retiree Carry-Over Coverage prior to January 1, 2025, may continue their Retiree Carry-Over Coverage until the later of January 1, 2026 or 12 total months of Retiree Carry-Over Coverage. Afterwards, such participants will be required to have 20 years of Earned Coverage years to requalify for Retiree Carry-Over Coverage.

Your Retiree Carry-Over Coverage will commence when all requirements have been met and all Earned Coverage has been exhausted.

For example:

If you have earned two Retiree Carry-Over Credits, accumulated 20 years of Earned Coverage, retired effective July 1, 2025, exhausted your Earned Coverage as of June 30, 2025, and your 65th birthday is on August 15, 2025, you will be eligible to begin using your Retiree Carry-Over Credits on August 1, 2025.

One Retiree Carry-Over Credit provides coverage for one 12-month Benefit Period. 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:

If your Retiree Carry-Over Coverage begins on July 1, 2025 and you subsequently qualify for Earned Coverage beginning on January 1, 2026, your Retiree Carry-Over Coverage will end on December 31, 2025 and that Retiree Carry-Over Credit will be considered fully exhausted.

Years of coverage through Retiree Carry-Over Credit will not be credited as Earned Coverage years and will not count towards eligibility for Certified Retiree status and Extended Self-Pay Coverage.

If you continue health coverage through Retiree Carry-Over Credits and also qualify for Certified Retiree Coverage (please see the section titled *Certified Retiree Coverage* beginning on page 25 for more information), you will be automatically switched to Certified Retiree Coverage after your coverage through Retiree Carry-Over Credits ends. Your Retiree Carry-Over premium will be lower if you also qualify for Certified Retiree Coverage.

Retiree Carry-Over Coverage includes medical coverage, prescription drug coverage and vision coverage. Dental coverage is also available for an additional monthly premium. You may choose not to elect dental coverage. However, once you decline dental coverage, you may not elect it again in the future. In addition, you cannot receive dental coverage without medical coverage.

Dependent children may be eligible to self-pay for health coverage at a reduced Kid's COBRA rate. See the section titled *Dependent Children of Retirees (Kid's COBRA)* beginning on page 35 for more information.

Your Retiree Carry-Over Coverage will end before the maximum duration of coverage if:

- you begin Earned Coverage;
- you do not pay the premiums on time; or
- the Health Plan no longer provides group healthcare coverage for its participants or eliminates Retiree Carry-Over Coverage (but not before the applicable COBRA continuation period ends).

If you are eligible for Retiree Carry-Over Coverage and your coverage ends before the maximum duration of coverage for any of the reasons listed above (including declining coverage or failure to elect Retiree Carry-Over Coverage), you will lose all accumulated Retiree Carry-Over Credits.

If you are on Retiree Carry-Over Coverage, you will be covered under the DGA Premier Choice Plan.

(2) Election of Retiree Carry-Over Coverage

You will receive a notice from the Health Plan office once the Health Plan has established that you are eligible for Retiree Carry-Over Coverage. You must notify the Health Plan office of your intention to elect such coverage by returning the election form or remitting the applicable premium for such coverage to the Health Plan office within 30 days of the date you are eligible to begin Retiree Carry-Over Coverage.

For example:

If you are eligible to begin Retiree Carry-Over Coverage on January 1, 2025, you must notify the Health Plan office of your intention to elect such coverage by January 31, 2025.

If you fail to notify the Health Plan office within the 30-day deadline, you will permanently lose the right to elect Retiree Carry-Over Coverage in the future.

When your Retiree Carry-Over Coverage runs concurrent with COBRA Continuation Coverage, you will have 60 days to elect the coverage.

(3) Certified Retiree Coverage

Certified Retiree Coverage is health coverage at a significantly reduced premium for you and your eligible spouse.

You qualify for Certified Retiree Coverage if you:

- are at least age 60;
- have at least 20 years of Earned Coverage; and
- are currently receiving (or have received) a pension benefit from either the DGA Basic or Supplemental Plans.

If you started receiving (or have received) a benefit from either the DGA Basic or Supplemental Plans on or after July 1, 2006, you can continue accruing Earned Coverage years toward eligibility for Certified Retiree Coverage. If you started receiving a pension benefit from either the Basic or Supplemental Plans prior to July 1, 2006, and before completing 20 years of Earned Coverage, you will not be able to accrue Earned Coverage years toward eligibility for Certified Retiree Coverage, except if you were forced to begin taking your retirement benefits because you reached the mandatory retirement age.

If you are totally disabled and receiving disability benefits from Social Security, the age 60 requirement does not apply, but you must still meet the other two requirements (*i.e.*, have at least 20 years of Earned Coverage and are currently or have received a pension benefit from the DGA Basic or Supplemental Plans).

The 20 years of Earned Coverage required to become eligible for Certified Retiree Coverage may be either Earned Active Coverage or Earned Inactive Coverage (refer to the section titled *Active vs. Inactive Coverage* beginning on page 10 for more information). Years of COBRA Continuation

Coverage or self-pay coverage do not count towards the 20 years of Earned Coverage requirement.

If you are on Certified Retiree Coverage, you will be covered under the DGA Premier Choice Plan (see the section titled *DGA Premier Choice & DGA Choice Plans* beginning on page 49 for more information).

Certified Retiree Coverage includes medical, prescription drug and vision coverage. Dental coverage is also available for an additional monthly premium. You may choose not to elect dental coverage. However, once you decline dental coverage, you may not elect it again in the future. In addition, you cannot receive dental coverage without medical coverage.

If you continue health coverage through Certified Retiree Coverage and also qualify for Retiree Carry-Over Coverage, you will automatically be switched to Retiree Carry-Over Coverage once you become Medicare eligible at age 65. Once you have exhausted your Retiree Carry-Over Coverage, you will automatically be switched back to Certified Retiree Coverage.

Dependent children may be eligible to self-pay for health coverage at a reduced Kid's COBRA rate. See the section titled *Dependent Children of Retirees (Kid's COBRA)* beginning on page 35 for more information.

Your Certified Retiree Coverage will end if:

- you begin Earned Coverage;
- you do not pay the premiums on time;
- in the case of Social Security disability, the Social Security Administration determines that 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 healthcare coverage for its participants or eliminates

Certified Retiree Coverage (but not before the applicable COBRA continuation period ends).

In order to maintain your eligibility for Certified Retiree Coverage, you must maintain coverage continuously with the Health Plan by either paying the Certified Retiree premiums or satisfying the minimum earnings threshold for Earned Coverage. If you begin Certified Retiree Coverage prior to age 60 because of total disability and your Certified Retiree Coverage ends because the Social Security Administration determines that you are no longer totally disabled, you will be able to resume Certified Retiree Coverage at age 60. If you have a lapse in coverage (except in the case of loss of total disability status), you and your spouse will become permanently ineligible for Certified Retiree Coverage.

(4) Election of Certified Retiree Coverage

You will receive a notice from the Health Plan office prior to becoming eligible to begin Certified Retiree Coverage. You must notify the Health Plan office of your intention to elect such coverage by returning the election form and remitting the applicable premium for such coverage to the Health Plan office within 30 days of the date on which you are eligible to begin Certified Retiree Coverage. If you fail to notify the Health Plan office within 30 days, you will permanently lose your right to elect Certified Retiree Coverage in the future. When Certified Retiree Coverage is concurrent with COBRA Continuation Coverage, you have 60 days to make the coverage election.

For example:

If you are eligible to begin Certified Retiree Coverage on January 1, 2025, you must notify the Health Plan office of your intention to elect such coverage by January 31, 2025.

(d) Self-Pay Plans at a Glance

If you are eligible for COBRA Continuation Coverage or Extended Self-Pay Coverage, you have the option of choosing between one of the following coverage levels:

- DGA Gold Plan
- DGA Silver Plan
- DGA Bronze Plan

Refer to the section titled *Self-Pay Plans* beginning on page 50 for a table that details each.

(1) DGA Gold Plan

DGA Gold Plan coverage provides the same benefits as the Earned Coverage that you were covered under immediately prior to beginning your DGA Gold Plan coverage (*i.e.*, medical, dental, prescription drug and vision benefits).

If you were covered under the DGA Premier Choice Plan immediately prior to beginning self-pay coverage, you may choose the DGA Gold Plan with DGA Premier Choice benefits or the DGA Gold Plan with DGA Choice benefits. If you were covered under the DGA Choice Plan immediately prior to beginning self-pay coverage, you may only choose the DGA Gold Plan with DGA Choice benefits. For more information on the difference between DGA Premier Choice and DGA Choice benefits, refer to the section titled *DGA Premier Choice & DGA Choice Plans* beginning on page 49. When using a Non-Network provider under the DGA Premier Choice Plan, the Health Plan will cover 70% of the Reasonable and Customary Allowed Amount for Covered Expenses and 60% of the Reasonable and Customary Allowed Amount for Covered Expenses under the DGA Choice Plan.

(A) DEDUCTIBLE

\$325 per individual per Plan Year
\$975 per family per Plan Year (DGA Premier Choice or DGA Choice level)

(B) CO-INSURANCENetwork:

Health Plan pays 90%; you pay 10%

Non-Network:

Premier Choice: Health Plan pays 70% of the Reasonable and Customary Allowed Amount; you pay 30% of the Reasonable and Customary Allowed Amount
 Choice: Health Plan pays 60% of the Reasonable and Customary Allowed Amount; you pay 40% of the Reasonable and Customary Allowed Amount

(C) CO-INSURANCE MAXIMUMNetwork:

\$1,000 per individual per Plan Year

Non-Network:

Premier Choice: \$12,500 per individual per Plan Year
 Choice: \$20,000 per individual per Plan Year

(D) ALL-INCLUSIVE NETWORK OUT-OF-POCKET LIMITNetwork:

\$9,200 per individual per Plan Year
 \$18,400 per family per Plan Year

Non-Network:

None

(2) DGA Silver Plan

DGA Silver Plan coverage offers the same medical and prescription drug coverage as is offered under the DGA Gold Plan (Choice level). It does not include dental or vision coverage.

(A) DEDUCTIBLE

\$325 per individual per Plan Year
 \$975 per family per Plan Year

(B) CO-INSURANCENetwork:

Health Plan pays 90%; you pay 10%

Non-Network:

Health Plan pays 60% of the Reasonable and Customary Allowed Amount; you pay 40% of the Reasonable and Customary Allowed Amount

(C) CO-INSURANCE MAXIMUMNetwork:

\$1,000 per individual per Plan Year

Non-Network:

\$20,000 per individual per Plan Year

(D) ALL-INCLUSIVE NETWORK OUT-OF-POCKET LIMITNetwork:

\$9,200 per individual per Plan Year
 \$18,400 per family per Plan Year

Non-Network:

None

The following benefits are not provided under the DGA Silver Plan:

- Vision
- Dental

(3) DGA Bronze Plan

DGA Bronze Plan coverage provides medical coverage only and has the same benefit design as the other self-pay plans except for the following:

(A) DEDUCTIBLE

\$750 per individual per Plan Year
 \$2,250 per family per Plan Year

(B) CO-INSURANCENetwork:

Health Plan pays 70%; you pay 30%

Non-Network:

Health Plan pays 50% of the Reasonable and Customary Allowed Amount; you pay 50% of the Reasonable and Customary Allowed Amount

(C) OUT-OF-POCKET MAXIMUM

Network:

\$9,200 individual per Plan Year

\$18,400 family per Plan Year

(includes Deductibles, Co-Payments and Co-Insurance for medical claims)

Non-Network:

No limit (does not include Deductibles or Co-Payments)

(D) ALL-INCLUSIVE NETWORK OUT-OF-POCKET LIMIT

Network:

\$9,200 per individual per Plan Year

\$18,400 per family per Plan Year (includes

Deductibles, Co-Payments and Co-Insurance for medical claims)

Non-Network:

None

The following benefits are not provided under the DGA Bronze Plan:

- Prescription drugs (other than preventive care drugs as required by ACA)
- Vision
- Dental
- Special arrangements with UCLA Health/EIMG

(e) Self-Pay Premiums

If you are self-paying for coverage, the amount of your self-pay premium will be based on the number of dependents covered and whether you or your dependents are eligible for Medicare.

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

Payments can be made by check, credit card, bank account debit or monthly pension deduction. You can only make self-pay premium payments through monthly pension deductions if you are receiving a monthly pension benefit and have sufficient funds

from the DGA Basic Plan to cover the entirety of the premium payment. Restrictive language on checks paying self-pay premiums will not change the Health Plan's self-pay premium rates.

Premium rates are reviewed periodically and subject to change. Quarterly, semi-annual and annual rates are based on the current monthly rate and are subject to change if the monthly rate changes. If you have prepaid and the rates subsequently change, you will be required to pay any additional amounts due. The Health Plan will invoice you for the balance.

For specific rules regarding COBRA Continuation Coverage premiums, refer to the section titled *COBRA Premium Payments* beginning on page 21.

(f) Switching Self-Pay Plans

You may change the self-pay plan during your applicable Open Enrollment Period (see the section titled *Making Changes to Your Health Coverage* beginning on page 14 for more information) or Special Enrollment Period (see the section titled *Special Enrollment Rights* beginning on page 34 for more information).

Once you elect self-pay coverage, you may not switch to a more expensive plan outside of open enrollment and any subsequent Open Enrollment Period(s) for the duration of the self-pay coverage (unless you subsequently requalify for Earned Coverage).

For example:

If you elect the DGA Bronze Plan on January 1, 2025, you may not move to the DGA Gold Plan or the DGA Silver Plan unless you are within your Open Enrollment Period, which would end March 1, 2025. If you subsequently requalify for Earned Coverage, you will be able to elect any available self-pay option at the end of your Earned Coverage.

(g) Special Rules For Qualified Military Service

If you enter qualifying military service, you will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), as amended. If you begin a period of service in the Uniformed Services, you and your eligible dependents may be eligible for Uniformed Services coverage under the Health Plan for the period of time you are in the Uniformed Services, up to 24 months. In the alternative, you may elect COBRA Continuation Coverage for up to 18 months (see the section titled *COBRA Continuation Coverage* on page 16 for more information).

In order to be eligible for Uniformed Services coverage, you must have departed for Uniformed Service during a Benefit Period in which you were covered, and must satisfy the applicable premium amounts in one of the following two ways:

- You may pay 102% of the premium for the 24-month period and freeze the portion of Earned Coverage available to you when you began performing service in the Uniformed Services. In no event may you freeze Earned Coverage for more than five years. Upon your return from Uniformed Service, you may utilize the frozen Earned Coverage, provided you notify the Health Plan office of your intent to resume coverage, and you resume coverage within one year of your return from Uniformed Service.
- You may deplete your Earned Coverage and continue providing for coverage for the remainder of the 24-month period by paying 102% of the premium.

If you earn coverage while serving because of contributions on residuals, you will continue to have the right to use that Earned Coverage immediately or freeze that Earned Coverage for up to five years of Uniformed Service.

Non-Collectively Bargained Employees who return from Uniformed Service to work with their former Employer (including the Directors Guild of America-Producer Pension and Health Plans or the Directors Guild of America) and who have fewer than five years of cumulative Uniformed Service will be eligible for coverage immediately upon reemployment.

If you need assistance in determining whether your service is considered qualifying military service (*i.e.*, Uniformed Services) under the Health Plan, please contact the Health Plan office.

(h) Terminating Your Self-Pay Coverage

You may terminate your self-pay coverage by notifying the Health Plan office in writing. If you request to terminate your self-pay coverage, it can only be terminated effective on the last day of a month and cannot be retroactively terminated.

Once terminated, coverage cannot be reinstated on a self-pay basis.

(i) Underpayment or Partial Payment of Health Premiums

The Health Plan’s acceptance and deposit of any payment(s) for premiums or any other amounts owed (*e.g.*, health premiums, COBRA premiums, self-pay premiums), including the cashing of any instrument(s) (*e.g.*, check(s) or money order(s)), shall not release or discharge you from your obligations to the Health Plan for the balance of any amounts that are still owed, notwithstanding any statement, condition, restriction, or any other qualification appearing on the instrument or any accompanying communication. Such acceptance and deposit by the Health Plan are not intended, and shall not be construed as, waivers of the Health Plan’s rights and remedies, all of which are expressly reserved. The preceding provisions shall

not supersede or affect in any way the terms or enforceability of any written settlement or other agreement between you and the Health Plan.

Section 5. Covering Dependents

In order to cover your dependents under the Health Plan, they must meet the definition of an eligible dependent, and you must pay any applicable premiums on their behalf.

(a) Eligible Dependents

Eligible dependents do not include any relatives other than those described in this section. The following are eligible dependents:

(1) Your Lawful Spouse

Your lawful spouse is the individual who is legally married to you, as recognized under the laws of the state or jurisdiction in which the marriage was entered into. Same-sex and opposite-sex domestic partners are not eligible for coverage.

(2) Your Children Under Age 26

Your dependent children under age 26 are:

- your natural children or those of your spouse;
- your adopted children, beginning on the date of the placement for adoption;
- a child who you are the legal guardian for, beginning on the effective date of your legal guardianship;
- a child covered under a Qualified Medical Child Support Order (QMCSO); or
- any other children dependent upon you for the majority of their financial support, provided they are also: (1) living with you in a normal parent-child relationship, (2) you are in the process of becoming the legal guardian of such dependent, and (3) proof of these conditions can be verified by the Plan.

Foster children are not eligible dependents under the Health Plan.

Your children will remain eligible until the end of the month in which they turn age 26, or otherwise cease to qualify as an eligible dependent.

(3) Your Disabled Children Age 26 and Older

Your unmarried children age 26 and older will remain eligible dependents under the Health Plan as long as they continue to satisfy all of the following conditions and notification requirements below:

- the child is not capable of self-sustaining employment because of a mental or physical handicap and is considered medically to have incurred a total disability;
- the child is primarily dependent upon you for support and maintenance;
- the child's disability existed immediately prior to the child reaching age 26; and
- the child was covered by the Health Plan immediately prior to turning age 26 and has continuously been covered by you as a dependent under the Health Plan after turning age 26, except for periods during which you were covered under any applicable continuation coverage (*i.e.*, COBRA and/or self-pay).

A child may be an eligible adult dependent even if he or she was not disabled when first covered under the Health Plan, as long as he or she continues to satisfy the criteria above.

In addition to the above, you must also notify the Health Plan of your child's disability status when you first become covered under the Health Plan or when the child becomes disabled and prior to the child turning age 26 in order for your child to remain an eligible dependent after age 26.

As noted in the section titled *Verifying Eligible Dependents* on page 31, for children age 18

and over on your Retiree Coverage, you must also continue to remit documentation on an annual basis to confirm your child's current Social Security Disability Award is still valid.

After turning age 26, if the disabled dependent does not satisfy the aforementioned conditions to be an eligible dependent, the child will permanently lose the right to be considered a dependent child and will no longer qualify for health coverage with the Plan in the future.

For example:

1. Assume Participant A wants to enroll disabled child B as her dependent after age 26. B was born with a mental disability that makes it so B is not capable of self-sustaining employment. B has received a Social Security Disability Award confirming his total disability. B is also primarily dependent on Participant A for support and maintenance. Participant A notifies the Plan of B's disability status when A first became covered under the Health Plan and continues to comply with the Plan's annual notification requirements. B was covered under the Health Plan as an eligible dependent immediately prior to reaching age 26. Under the facts above, B would continue to be an eligible dependent of Participant A after turning age 26.

2. Assume the same facts as Example 1 above, except that Participant A loses Earned Coverage and elects COBRA Continuation Coverage for her and B when B is age 28. Before exhausting their COBRA coverage, Participant A requalifies for Active Coverage under the Health Plan. Under the facts above, when Participant A re-enrolls in the Health Plan, B would still be an eligible dependent of Participant A. This is because B has been continuously covered by Participant A as her dependent, and they also continue

to satisfy the other criteria to qualify as an adult dependent after age 26.

3. Assume the same facts as Example 1, except that Participant A loses Active Coverage when B is age 28. Participant A elects and exhausts her COBRA and self-pay coverage for herself only. One year after exhausting her continuation coverage (i.e., COBRA and self-pay), Participant A requalifies for Active Coverage with the Health Plan. Under the previous facts, when Participant A re-enrolls in the Health Plan, B would not be an eligible dependent of Participant A, as B has not been continuously covered by Participant A as her dependent.

4. Assume the same facts as Example 1, except that Participant A did not notify the Health Plan of her child's disability status when A first became covered under the Health Plan or when the child first became disabled prior to turning age 26. Under the previous facts, B would not be an eligible dependent after age 26, because Participant A failed to notify the Health Plan of her child's disability status when he or she first became covered under the Health Plan.

(b) Verifying Eligible Dependents

(1) Required Documentation For Verifying Eligible Dependents

In order to verify if your dependent qualifies as an eligible dependent, you must promptly send the Health Plan office a copy of any document or information requested that is necessary to confirm initial or continued eligibility as a dependent.

In addition to providing any such requested documentation or information, you are required to provide the documents described in the chart on the next page.

Required Documentation for Verifying Eligible Dependents

Marriage	<p>A copy of the certified marriage certificate. It can take several months to obtain a certified marriage certificate. When you get married, you may send an uncertified copy as a temporary documentation. You will be required to submit a copy of the certified marriage certificate within six months of the date of your marriage. To enroll a spouse as a dependent under your coverage, you must notify the Health Plan within 31 days from your marriage date.</p>
Divorce	<p>A copy of the final divorce decree or judgment of dissolution of marriage. For the ex-spouse or former stepchild(ren) to be eligible for COBRA Continuation Coverage due to loss of dependent status, the Health Plan office must be notified within 60 days from the date of divorce. Refer to the <i>COBRA Continuation Coverage</i> section beginning on page 16 for more information.</p>
Birth	<p>A copy of the child's certified birth certificate. It can take several months to obtain a certified birth certificate. When you have a child, you may send us an uncertified copy as temporary documentation, but you will be required to submit a copy of the certified birth certificate within six months of the date of birth. To enroll your child as a dependent under your coverage, you must notify the Health Plan within 31 days from the child's date of birth.</p>
Adoption/ Guardianship	<p>A copy of the adoption or guardianship documents. Documentation indicating temporary custody, temporary guardianship or foster status will not be sufficient to gain eligibility under the Health Plan. To enroll the child as a dependent under your coverage, you must notify the Health Plan within 31 days from the adoption/guardianship date and provide a copy of the child's certified birth certificate.</p>
Adult Dependent Child with Physical or Mental Disability	<p>Proof that you are providing at least half of your dependent's support. For children 26 and over who are covered as a dependent on your Retiree Coverage, you must remit documentation on an annual basis with a current Social Security Disability Award on behalf of that child. Refer to the section titled <i>Your Disabled Children Age 26 and Older</i> beginning on page 30 for more information.</p>

Eligibility

By participating in the Health Plan, you agree to cooperate with the Health Plan's reasonable efforts to audit and confirm the eligibility status of any dependent. Timely providing information or documents that are required or requested by the Health Plan is a condition of eligibility for benefits for your dependents. Therefore, if the information or documents are not provided timely, the Health Plan in its sole discretion may determine that your dependent does not qualify as a dependent or loses continued eligibility as a dependent. You may be held responsible for any overpayment(s) resulting from your failure to confirm the eligibility status of your dependents.

(2) Dependent Social Security Numbers Required

To comply with federal Medicare coordination of benefits regulations and certain IRS reporting rules, you must promptly furnish to the Health Plan, or its designee, the social security number ("SSN") of any Eligible Dependent for whom you have elected or are electing Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is free.

(3) Special Criteria For Disabled Dependent Children Who Do Not Satisfy Social Security Administration's Resource Limit or Residency Requirements

When a disabled dependent child age 18 and over does not meet the resource limit or residency requirements to qualify for Social Security disability benefits, the Health Plan's Board of Trustees will determine whether the individual is disabled under the following definition:

Disability is defined as the inability to engage in any occupation for wage or profit for which the individual is reasonably qualified by reason of education, training or experience. The inability must be as a result of injury or Sickness and must be verified by an attending Physician's statement.

In the case described above, you will be required to provide the following for purposes of confirming the child's disability status:

- a copy of the most recent tax return that shows the child is claimed as a dependent for tax purposes;
- a completed Physician's statement that is to be obtained at your cost;
- a completed disability application (the application is available by contacting the Health Plan office); and
- pertinent medical records as may be required by the Health Plan's independent medical review firm.

The Health Plan will periodically require updated documentation to confirm that a disabled dependent child age 26 and over who does not meet Social Security resource limit or residency

requirements continues to meet the definition detailed previously.

For purposes of determining dependent eligibility, disabled dependent children under age 26 do not need to submit proof of disability under Earned Coverage, COBRA Continuation Coverage or Extended Self-Pay Coverage.

For disabled dependent children under age 26 covered under Retiree Coverage, you must submit documentation on an annual basis demonstrating that your dependent is mentally or physically disabled. This documentation will be reviewed by the Health Plan's medical review firm.

(c) Dependent Premium

If you qualify to receive Earned Coverage, payment of a dependent premium is required to receive health coverage for your spouse and/or eligible dependent children.

The Health Plan's dependent premium for you and your dependents on Earned Coverage is structured as follows (↓):

Enrollment	Annual Premium
Participant Only	No premium
Participant + 1 Dependent	\$780
Participant + 2 or more Dependents	\$1,200

The dependent premium can be paid semi-annually (\$390 or \$600 for six months) or annually (\$780 or \$1,200 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.

For example:

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 any required dependent premium. If the dependent premium is not received by the Health Plan during the 30-day grace period, your dependent will not be eligible for coverage until the beginning of your next Benefit Period, unless he or she has a Special Enrollment Right. Refer to the section titled *Special Enrollment Rights* below for more information.

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.

(d) Special Enrollment Rights

If you decline enrollment into the Health Plan during open enrollment for yourself or your dependents because of other health insurance or group health coverage, or you decline COBRA or self-pay coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Health Plan if you or your dependents lose eligibility for that other coverage in the future (or if the Employer stops contributing towards your or your dependents' other coverage). In addition, if you decline enrollment for yourself or your dependents because of Medicaid or a state Children's Health Insurance Program ("CHIP") and such coverage is terminated due to the loss of eligibility, or if you or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in the Health Plan. In either case, you must request enrollment from the Health Plan office within 60 days after the other

coverage ends, when you and your dependent become eligible for premium assistance, or after the Employer stops contributing towards the other coverage. The dependent premium will not be prorated if you add a dependent pursuant to this paragraph to your Earned Coverage. You must verify the date that other coverage ends for you or your dependents with the Health Plan.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. If you timely request to Special Enroll in the Health Plan due to birth, adoption or placement for adoption of a dependent child, the coverage will become effective as of the date of the child's birth, adoption or placement for adoption. If a timely Special Enrollment request is made due to marriage, coverage under the Health Plan will become effective as of the date of the marriage. The dependent premium will not be prorated if you add a dependent pursuant to this paragraph to your Earned Coverage.

If you have a new dependent and there is no additional dependent premium due to cover this dependent, you may add your new dependent at any time provided that:

- coverage will be effective not more than 12 months before the Health Plan is notified of the new dependent; and
- coverage will begin on the date that your Earned Coverage began or the date that you acquired the dependent, whichever is later.

For example:

If you paid the entire dependent premium due for your spouse and your child during the January 1, 2025 to December 31, 2025

Benefit Period, and you and your spouse have another child on June 17, 2025, you would be eligible to add your child to your coverage effective June 17, 2025, provided you notify the Health Plan by June 16, 2026.

If you have a new dependent and there is an additional dependent premium due to cover this new dependent, you may add your new dependent:

- only during your annual Open Enrollment Period; or
- only if your new dependent qualifies for Special Enrollment and payment for the additional dependent premium is made.

If one of your dependents is not currently covered under the Health Plan and is offered coverage through his or her employer but declines that coverage, the dependent will not qualify for Special Enrollment coverage. For individuals who have other non-COBRA Coverage, the right to Special Enrollment arises if the coverage was terminated as a result of loss of eligibility for that coverage.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements as are available to similarly-situated employees at initial enrollment.

(1) COBRA Continuation Coverage

The Health Plan provides Special Enrollment Rights to your dependent upon loss of another employer's coverage even if your dependent is eligible for COBRA Continuation Coverage. However, if you or your dependent(s) lose COBRA Continuation Coverage as a result of failure to pay the required COBRA premium, your dependent will not be eligible for enrollment until your next Open Enrollment Period.

To request Special Enrollment or to obtain more information, please contact the Health Plan office.

(e) Coverage for Newborn Children

Your children with Earned Coverage or coverage through any of the Health Plan's self-pay programs are covered for the first 31 days after birth, adoption or placement for adoption.

(f) Qualified Medical Child Support Orders

If you have a Qualified Medical Child Support Order ("QMCSO"), you may be required to cover your eligible dependent children under the Health Plan. Upon receipt of a QMCSO, 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.

(g) Dependent Children of Retirees (Kid's COBRA)

Non-disabled dependent children of retirees are not eligible for coverage under your Retiree Coverage. However, dependent children in existence and covered under the Health Plan at the time that you begin Retiree Coverage are eligible to self-pay for health coverage at a special reduced Kid's COBRA rate. This coverage is available to eligible dependent children up to the end of the month in which the dependent turns age 26.

Retiree Kid's COBRA runs concurrently with COBRA Continuation Coverage. If the child turns age 26 prior to completing at least 36 months of Kid's COBRA Coverage, the child will be offered COBRA Continuation Coverage for the remainder of the 36 months that he or she would have been eligible to continue Kid's COBRA Coverage.

For example:

If a dependent child is on Retiree Kid's COBRA Coverage and turns age 26 during the 12th month of that coverage, he or she

would be offered up to 24 months of COBRA Continuation Coverage.

A dependent child acquired after you begin Retiree Coverage is not eligible for coverage under the Health Plan (with the exception of the first 31 days after birth, refer to the section titled *Coverage for Newborn Children* beginning on page 35), unless you subsequently become eligible for Earned Coverage. If you qualify for Earned Coverage after beginning Retiree Coverage, any dependent child (up to age 26) covered under your Earned Coverage will be eligible for Kid's COBRA Coverage when you transition from Earned Coverage to Retiree Coverage.

Your disabled dependent children are eligible dependents under your Retiree Coverage provided they:

- were covered under your Health Plan coverage immediately prior to you commencing Retiree Coverage; and
- met the Health Plan's criteria for disability status (as detailed in the next paragraph) immediately prior to you commencing Retiree Coverage.

For disabled dependent children under age 26 or disabled children age 26 and over who do not meet the resource limit or residency requirements to qualify for Social Security benefits, a third-party medical review process will be used to determine the dependent child's disability status. Refer to the section titled *Special Criteria for Disabled Dependent Children Who Do Not Satisfy Social Security Administration's Resource Limit or Residency Requirements* beginning on page 33 for more information. For disabled dependent children age 26 and over, a Social Security Disability Award must be provided in order for the adult dependent child to continue coverage under the Health Plan.

The Health Plan will require an updated Social Security Disability Award on an annual basis to

confirm that the adult dependent child continues to be disabled.

No premium is charged to cover disabled dependent children under your Retiree Coverage.

(h) Children's Health Insurance Program (CHIP) Notice

If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") but are unable to afford the premiums, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but who also have access to health insurance through their employer. If you or your children are NOT eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, or if you think you might be eligible for Medicaid or CHIP, you can contact your state Medicaid or CHIP office or go to www.insurekidsnow.gov to find out if premium assistance is available. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible but not already enrolled in the employer's plan. This is called a Special Enrollment opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Section 6. When Dependent Coverage Ends

Coverage for your dependent child will stop on the earliest of the following:

- the date he or she no longer qualifies as an eligible dependent under the terms of the Plan; or
- the date your coverage terminates, or in the event of your death, the date coverage for your surviving spouse terminates.

If you are on Retiree Coverage, coverage for your dependent child will end 32 days after the date your coverage begins.

(a) Dropping Dependent Coverage

If you are self-paying for coverage or if you have Earned Coverage and are paying the dependent premium, you may voluntarily drop your dependents from your coverage effective at the end of the month in which you notify the Health Plan that you wish to drop your dependents from coverage. This may be subject, however, to any Qualified Medical Child Support Order or other court order which could preclude termination of coverage.

When dropping your dependents results in only you remaining covered under the Health Plan, you will only be entitled to a refund of the dependent premiums paid for periods after the current six-month premium period.

For example:

If you paid the dependent premium for the period January 1, 2025 to December 31, 2025, your two premium periods would be January 1, 2025 to June 30, 2025 and July 1, 2025 December 31, 2025. If you subsequently dropped your dependents effective March 31, 2025, you would only be eligible for a refund of the premium paid

for the period July 1, 2025 to December 31, 2025 (i.e., the second of the two six-month premium periods).

A dependent voluntarily dropped from self-pay coverage or Earned Coverage can only be added back onto your coverage during your next Open Enrollment Period, unless the dependent has a Special Enrollment Right.

In cases of involuntary loss of a dependent's coverage for any reason (e.g., you become divorced from your spouse, your child no longer meets the age requirements, etc.), you or your dependents must notify the Health Plan within 60 days. Refer to the section titled *COBRA Continuation Coverage* beginning on page 16 for more information concerning these notice requirements. 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. You will also be required to reimburse the Health Plan interest on any amounts paid on behalf of your dependent and any amounts expended by the Health Plan as a result of collection efforts of the Health Plan, including legal fees.

Section 7. Dependent Coverage Extensions Upon Your Death

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

(a) Participants on Earned Coverage or Carry-Over Coverage

If your surviving spouse was covered as an eligible dependent on Earned Coverage at the time of your death, he or she will continue to be covered for the remainder of any Earned Coverage you had accumulated prior to your death, provided you and

your surviving spouse were married for a minimum of two years (*i.e.*, 24 months) prior to your death.

Your surviving spouse's inherited coverage will terminate upon the earlier of:

- the date the remaining Earned Coverage expires; or
- the date the surviving spouse remarries or fails to timely provide to the Health Plan (upon the Health Plan's request) with an affidavit attesting to his or her marital status or any other documentation requested by the Health Plan necessary to confirm marital status. It is the surviving spouse's responsibility to notify the Health Plan of a new marriage. If a surviving spouse fails to do so, or fails to provide the affidavit referred to above, or other information requested by the Health Plan to confirm his or her marital status, he or she will be held liable for any claims overpayments made as a result of failing to notify the Health Plan.

Your surviving spouse's inherited coverage will continue, provided the applicable dependent premiums are paid on a timely basis, until the date any remaining Earned Coverage expires.

Your Carry-Over Credit may be used by your surviving spouse to meet the eligibility requirements for Carry-Over Coverage. The dependent premium remains due on behalf of a surviving spouse covered under your Carry-Over Coverage.

After this extension terminates, a 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 in the *COBRA Continuation Coverage* section beginning on page 16.

Surviving dependent children will be covered with your surviving spouse for as long as the surviving dependent children qualify as eligible dependents (see the section titled *Eligible Dependents* beginning on page 30) and payment of the dependent premium is made on their behalf. If there is no surviving spouse, your surviving dependent child(ren) who were covered as eligible dependents at the time of your death will continue to be covered for the remainder of any Earned and Carry-Over Coverage you had accumulated prior to your death provided the applicable premiums are paid on a timely basis, until the date any remaining Earned and/or Carry-Over Coverage ends. Thereafter, coverage may be continued by making payments in accordance with COBRA. Refer to the section titled *COBRA Continuation Coverage* beginning on page 16 for additional information.

For coordination of benefits purposes, your surviving dependents with Earned Active Coverage will change from Earned Active Coverage to Earned Inactive Coverage effective on the date of your death.

(b) Participants on COBRA Continuation Coverage

Your surviving spouse and eligible dependent children are eligible to receive up to 36 months of COBRA Continuation Coverage from the date on which your Earned Coverage terminates. For more information on COBRA rules, refer to the section titled *COBRA Continuation Coverage* beginning on page 16.

(c) Participants on Extended Self-Pay Coverage

Your surviving spouse is entitled to the remainder of your Extended Self-Pay Coverage that you had accumulated prior to your death, provided you and your surviving spouse were married for a minimum of two years (*i.e.*, 24 months) prior to your death.

The inherited coverage will terminate upon the earlier of:

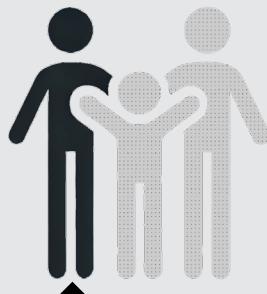
- the date the remaining self-pay coverage expires; or
- the date the surviving spouse remarries or fails to timely provide to the Health Plan (upon the Health Plan's request) an affidavit attesting to his or her marital status, or any other

documentation requested by the Health Plan necessary to confirm marital status. It is the surviving spouse's responsibility to notify the Health Plan of a new marriage. If a surviving spouse fails to do so, or fails to provide the affidavit referred to previously, or other information requested by the Health Plan to confirm that status, he or she will be held liable for any claims overpayments made as a result of failure to notify the Health Plan.



How It Works:

Dependent Coverage Extensions Upon Your Death: Participants on Extended Self-Pay Coverage



If you are entitled to 60 months of Extended Self-Pay Coverage...

60 months of Extended Self-Pay Coverage

...and you die with 40 months remaining (including COBRA to which you are entitled)...



40 months remaining



Your surviving spouse would be entitled to...

... 36 months of COBRA Continuation Coverage
(due to the qualifying event of the participant's death)



+ 4 months of Extended Self-Pay Coverage

(the balance of your 40 months of Extended Self-Pay Coverage minus 36 months of the surviving spouse's COBRA Continuation Coverage)



Your surviving dependent children would be entitled to...

Your surviving dependent children will be covered with your surviving spouse for as long as the surviving dependent children satisfy the definition of an eligible dependent (see the *Eligible Dependents* section beginning on page 30 provided the applicable premiums are paid. If there is no surviving spouse, eligible dependent children may continue coverage by making payments in accordance with COBRA. Refer to the *COBRA Continuation Coverage* section beginning on page 16 for additional information.

The inherited coverage will continue, provided the applicable premiums are paid on a timely basis, until the earlier of the following:

- the date any self-pay coverage expires; or
- the date the surviving spouse dies.

Additionally, if you were on Extended Self-Pay Coverage at the time of your death, your surviving spouse is entitled to 36 months of COBRA Continuation Coverage (refer to the section titled *COBRA Continuation Coverage* beginning on page 16 for more information). The COBRA Continuation Coverage will begin on the date of your death and will run concurrently with the Extended Self-Pay Coverage. Any remaining Extended Self-Pay Coverage after the end of the COBRA Continuation Coverage will be extended to the surviving spouse. Refer to the graphic on the previous page (↔) for details.

(d) Participants Qualified for Certified Retiree Coverage

If you are eligible for Certified Retiree Coverage, your surviving spouse will inherit Certified Retiree Coverage even if you never began such coverage, provided you and your surviving spouse were married for a minimum of two years (*i.e.*, 24 months) prior to your death. Your surviving spouse will be eligible to begin this coverage when you would have been eligible for Certified Retiree status. If you were on Certified Retiree Coverage at the time of death, Certified Retiree Coverage for your surviving spouse will begin immediately. The inherited coverage will terminate upon the earlier of:

- the date on which the spouse remarries or fails to timely provide the Health Plan (upon the Health Plan's request) an affidavit attesting to marital status or any other documentation requested by the Health Plan needed to confirm marital status;

- the date on which the surviving spouse fails to pay the required premium for Certified Retiree Coverage; or
- the date on which the surviving spouse dies.

It is the surviving spouse's responsibility to notify the Health Plan of a new marriage. The surviving spouse will be held liable for any claims overpayments made as a result of the failure to notify the Health Plan.

(e) Participants on Certified Retiree or Retiree Carry-Over Coverage

If you are on Certified Retiree or Retiree Carry-Over Coverage, your surviving spouse will inherit such coverage upon your death. The inherited coverage will terminate upon the earlier of:

- the date coverage for any remaining Retiree Carry-Over Credits expire, if not otherwise eligible for Certified Retiree Coverage;
- the date the surviving spouse remarries or fails to timely provide to the Health Plan (upon the Health Plan's request) an affidavit attesting to the surviving spouse's marital status or other information requested by the Health Plan to confirm that status;
- the date the surviving spouse fails to pay the required premium; or
- the date the surviving spouse dies.

It is the surviving spouse's responsibility to notify the Health Plan of a new marriage. If a surviving spouse fails to do so or fails to provide the affidavit referred to above or other information requested by the Health Plan to confirm that status, he or she will be held liable for any claims overpayments made as a result of failing to notify the Health Plan.

(f) Premium Rates for Dependents Upon Your Death

Your surviving spouse on COBRA, Extended Self-Pay, Retiree Carry-Over or Certified Retiree Coverage may continue receiving coverage at the applicable premium rates, as adjusted from time to time. Premium rates are subject to change. The amount of coverage premiums for a surviving spouse is determined by the surviving spouse's eligibility for Medicare.

Section 8. Other Coverage Extensions

(a) Coverage Extension During Total Disability

If you or a dependent have a total disability on the date your coverage is terminated, medical benefits will be continued only for treatment of the Sickness or injury that caused the total disability. No benefits are payable with respect to any other Sickness or injury. Benefits will be continued until the earliest of the following:

- 12 months from the date premium payments ceased for you or your dependent;
- 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.

For the purpose of this coverage extension, total disability is defined as:

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

There is no premium due for this coverage extension, and coverage does not include dental, vision or prescription benefits.

(b) Dental Coverage Extensions

See the section titled *Dental Coverage Extensions* beginning on page 93 for explanation of the special dental coverage extensions.

ARTICLE IV. MEDICAL BENEFITS

For additional information about medical benefits available, visit www.dgaplans.org/medical-benefits-overview.

Section 1. Health Plan Terms

Before you read the details of the Health Plan, you should familiarize yourself with a few of the common terms that will be used throughout this Summary Plan Description.

(a) Allowable Charge

The Allowable Charge is the maximum amount that the Health Plan will allow for each covered medical procedure or service. This allowance is subject to applicable Co-Payments, Co-Insurance and Deductibles. In the case of charges billed by a Non-Network provider, the Allowable Charge is based on the Reasonable and Customary Allowed Amount, except in the case of Emergency Services, when you receive Emergency or non-Emergency Services from a Non-Network provider at certain Network facilities, or air ambulance services provided by Non-Network providers. For other covered procedures and services, the Allowable Charge may be based upon an amount set in the Health Plan.

For example:

The maximum Allowable Charge for Chiropractic Care is \$50 per visit.

any amounts that exceed Covered Expenses, except in the case of Emergency Services, when you receive Emergency or non-Emergency Services from a Non-Network provider at certain Network facilities, or when air ambulance services are furnished by Non-Network providers.

For example:

Example 1. A Non-Network provider charges you \$100 and the Allowable Charge is \$70, the provider may balance bill you for the remaining \$30. You are also responsible for any applicable Co-Insurance and Deductible amounts.

On the other hand, if the negotiated Network rate for that same service is \$50, a Network provider may only charge \$50, of which you will be responsible for a percentage in accordance with your annual Deductible and Co-Insurance rate. A Network provider will not balance bill you for any amounts in excess of the negotiated Network rate.

Example 2. Same facts as 1 above, except you are seen by the Non-Network provider for Emergency Services after January 1, 2022. In that situation, the Non-Network provider may not balance bill you for any amounts that exceed Covered Expenses (in this case the remaining \$30). In addition, you will pay the same Cost-Sharing on the Non-Network claim that applies to Network claims. This result would be the same if you received Emergency or non-Emergency Services from a Non-Network provider at certain Network facilities, or air ambulance services by a Non-Network provider.

(b) Balance Billing

Balance Billing refers to when a provider bills the patient for the difference between the provider's billed amount and the Health Plan's Allowable Charge. Network providers may not balance bill you for any amount that exceeds the Covered Expenses. Non-Network providers, however, may balance bill you for

(c) Deductible

Before most benefits are payable by the Health Plan, you must satisfy the calendar year Deductible.

The Deductible is the amount you owe for healthcare services before the Health Plan begins to pay your claims each calendar year. For example, if your Deductible is \$325, the Health Plan will not pay any covered healthcare services until you have met your \$325 Deductible. The Deductible may not apply to all services, such as preventive care services rendered by a Network provider. The Deductible is applied on a calendar year basis.

Your Deductible applies to both doctor and Hospital expenses, as well as all other related expenses that are covered under the Health Plan. Co-Payments and Network preventive care services do not count towards your Deductible.

If you have individual coverage, the Deductible is \$325 per calendar year. Claims are applied to the Deductible in the order they are processed, not based on when the services are performed. Once you have met your \$325 Deductible, the Health Plan will begin to pay benefits on Covered Expenses, less any applicable Co-Payments or Co-Insurance for which you are responsible.

If you have coverage for yourself plus one dependent, the Deductible is \$325 per individual per calendar year. Once each individual has met the \$325 Deductible, the Health Plan will pay benefits on Covered Expenses, less any applicable Co-Payments or Co-Insurance for which the participant is responsible.

When you have coverage for yourself plus two or more dependents, the family Deductible is \$975. The Deductible works as follows:

- if one family member has \$325 of Covered Expenses in the calendar year, no further Deductible will be charged to that family member, leaving a remaining Deductible of \$650 for the rest of the family;

- the Plan will not apply more than the individual Deductible amount to any one family member; and if three or more covered family members meet a combined Deductible amount of \$975 in one calendar year, no further Deductibles will be charged to the family for that year.

(d) Co-Insurance

Co-Insurance is your share of the costs of a covered healthcare service at a percentage of the Allowable Charge for the service, once your Deductible has been met.

For example:

For Network benefits under the DGA Premier Choice and DGA Choice Plan, the Health Plan pays 90% of the Allowable Charge. Your Co-Insurance is 10%.

Once you satisfy the annual Deductible, the Health Plan shares covered charges with you, as shown in the chart on the next page (→).

Once your Deductible has been met and a covered amount has been determined on your claim, you will be responsible for your portion of the Co-Insurance. If you use a Non-Network provider, other than for Emergency Services, Emergency or non-Emergency Services received from a Non-Network provider at certain Network facilities, or air ambulance services by a Non-Network provider, you will be responsible for either the 30% or 40% (or 50% under the DGA Bronze Plan) of the remaining Covered Expenses depending on your plan of coverage, as well as any amount above the Reasonable and Customary Allowed Amounts or amounts in excess of a specific plan benefit limit provided by either Network or Non-Network providers, including all non-Covered Expenses.

Co-Insurance Rates

	Network	Non-Network				
	<i>The amounts below are applicable to Covered Expenses only.</i>					
	DGA Premier Choice Plan	DGA Choice Plan	DGA Bronze Plan	DGA Premier Choice Plan	DGA Choice Plan	DGA Bronze Plan
Plan Pays	90% of Allowable Charge (i.e., Covered Expenses)	90% of Allowable Charge	70% of Allowable Charge	70% of Reasonable and Customary Allowed Amount for Covered Expenses*	60% of Reasonable and Customary Allowed Amount for Covered Expenses*	50% of Reasonable and Customary Allowed Amount for Covered Expenses*
Participant Pays	10% of Allowable Charge	10% of Allowable Charge	30% of Allowable Charge	30% of Reasonable and Customary Allowed Amount for Covered Expenses*	40% of Reasonable and Customary Allowed Amount for Covered Expenses*	50% of Reasonable and Customary Allowed Amount for Covered Expenses*

*For Non-Network services, other than Non-Network Emergency Services, Emergency or non-Emergency Services received from Non-Network providers at certain Network facilities, or air ambulance services furnished by Non-Network providers, you pay the difference between the Reasonable and Customary Allowed Amount and the amount billed in addition to the Co-Insurance amount.

For example:

Example 1. Assuming your Deductible is met, if you receive non-Emergency Service from a Non-Network provider and you are charged \$10,000 for a procedure that has a Reasonable and Customary Allowed Amount of \$2,500, the Plan will only pay Co-Insurance on the Reasonable and Customary Allowed Amount for the Non-Network claim. Your Co-Insurance would be 30% under the DGA Premier Choice Plan or \$750 (30% of \$2,500), and you would also be responsible for any amount exceeding the Reasonable and Customary Allowed Amount (\$7,500), making your total responsibility \$8,250.

Example 2. Same facts as 1 above, except you are seen by the Non-Network provider

for Emergency Services after January 1, 2022. In that situation, you would pay the same Co-Insurance that would apply to Network claims. For DGA Premier Choice Plan, your Co-Insurance would be 10% (instead of 30%), or \$250, and the Non-Network provider may not balance bill you for any amounts exceeding \$2,500. This result would be the same if you received Emergency or non-Emergency Services from a Non-Network provider at certain Network facilities, or air ambulance services by a Non-Network provider. Any amount above the PPO contractual rate would be a cost savings to you, because Non-Network providers are not allowed to balance bill beyond such rate in this case.



How It Works:

Allowable Charges, Deductibles and Co-Insurance

Joe's Diabetes Treatment

Joe has type 2 Diabetes—a well-controlled condition—and needs a year of routine network care. The charts below show how his Deductible, Co-Payment and Co-Insurance interact for the service incurred at a Network provider.

Joe's Charges		What Joe Pays	
Total charge	\$5,400	Deductible*	\$325
Allowable Charge	\$3,000	Co-Insurance	\$267.50 (3,000-325) x 10%
Health Plan's Deductible	\$325	Amount in excess of Allowable Charge	\$0
Joe's Network Co-Insurance	10%	Co-Payment	\$0
Joe's Co-Payment	\$0	Total Joe Pays	\$592.50

**The example above assumes Joe has not satisfied his annual Deductible.*

(e) Co-Payment

A Co-Payment is a fixed amount you pay for a covered healthcare service, usually paid at the time you receive the service.

For example, there is a \$50 Co-Payment per visit when you are seen in an emergency room.

(f) Co-Insurance Maximum

The annual Co-Insurance Maximum is the amount of Covered Expenses that you are required to pay after your annual Deductible and Co-Payments, if any, are satisfied. There is a separate Co-Insurance Maximum for Network and Non-Network providers.

(g) Network and Non-Network Providers

Network providers are doctors and Hospitals that have agreed to be part of the Health Plan's Preferred Provider Organization ("PPO") Network and to charge and accept a reduced rate when used by Health Plan participants. Network providers can not charge any additional amounts over the negotiated contractual rates.

Non-Network providers are doctors and Hospitals that are not affiliated with the Health Plan's PPO Network. Non-Network providers do not have an agreement with the Health Plan to charge or accept any set rate for services provided to participants. If you receive services from a Non-Network provider, you will be responsible for any amount billed

that exceeds the Covered Expenses by the Health Plan, except with respect to Emergency Services, Emergency or non-Emergency Services received from a Non-Network provider at certain Network facilities, and air ambulance services by a Non-Network provider. See section titled *Reasonable and Customary Allowed Amount* below for more information.

(h) Reasonable and Customary Allowed Amount

A Reasonable and Customary Allowed Amount, commonly referred to as “R&C,” only applies to Non-Network claims, other than Non-Network Emergency Services, Emergency or non-Emergency Services from a Non-Network provider at certain Network facilities, and Non-Network air ambulance services.

A Reasonable and Customary Allowed Amount is a charge or fee that is equal to the lesser of: (1) actual billed charges; (2) 150% of the applicable Medicare reimbursement rate for a specified procedure; or (3) in the event there is no Medicare reimbursement rate for a specified procedure or it cannot be determined based on the information submitted, the amount that would be paid to a similar provider for the same or similar service or item in the same geographic location or locality. Schedules of maximum Reasonable and Customary Allowed Amounts are adjusted periodically to reflect changes in Physicians’ charges.

The Health Plan’s maximum Allowable Charge for any medical procedure or service from a Non-Network provider will not exceed the applicable Reasonable and Customary Allowed Amount noted above.

You are responsible for any charges from Non-Network providers in excess of the maximum Allowable Charge and all non-Covered Expenses, except with respect to Emergency Services, non-Emergency Services received from a Non-Network provider at certain Network facilities, and air

ambulance services furnished by Non-Network providers.

(i) Out-of-Pocket Limit

The Health Plan limits the amount of Co-Insurance and other out-of-pocket expenses you and your dependents pay for covered services in a calendar year. The Out-of-Pocket Limit is based on Covered Expenses incurred within the corresponding calendar year, not when a claim is paid by the Health Plan.

The Out-of-Pocket Limit is the maximum amount of Covered Expenses that a participant is required to pay after any applicable Deductibles and Co-Payments. A new Out-of-Pocket Limit begins each calendar year and applies separately to each family member. In addition, the Network and Non-Network Out-of-Pocket Limits are calculated separately.

The Deductibles and Out-of-Pocket Limit are higher under the DGA Bronze Plan (see the *DGA Bronze Plan* section beginning on page 27) but work in the same manner.

Certain expenses do not count towards reaching the Out-of-Pocket Limit. These include:

- Deductibles;
- prescription drug expenses;
- emergency room Co-Payments;
- Non-Network Hospital Co-Payments (other than Non-Network Emergency Services, Emergency or non-Emergency Services received from a Non-Network provider at certain Network facilities, and air ambulance services by a Non-Network provider);
- charges in excess of Reasonable and Customary Allowed Amounts;
- non-Covered Expenses;
- dental benefits;

- vision benefits, including glasses and contact lenses; and
- charges, including Co-Payments, incurred at a UCLA/EIMG Health Center.

The All-Inclusive Network Out-of-Pocket Limit is a comprehensive out-of-pocket maximum which includes your Deductibles, Co-Payments and Co-Insurances on Covered Expenses provided by Network providers in a calendar year.

(1) Network Expenses

The Health Plan has two separate Network Out-of-Pocket Limits:

- The Co-Insurance Maximum for Network expenses incurred in a calendar year under both the DGA Premier Choice Plan and the DGA Choice Plan is \$1,000. The Co-Insurance Maximum for Network expenses incurred in a calendar year under the DGA Bronze Plan is \$9,200.
- The All-Inclusive Network Out-of-Pocket Limit is \$9,200 per individual and \$18,400 per family. This comprehensive limit includes all out-of-pocket costs: Deductibles, Co-Payments and Co-Insurance.

Under the DGA Premier Choice and DGA Choice Plans, your Deductible is \$325 for individual coverage and \$975 for family coverage (two or more dependents). That means you pay the first \$325 of medical claims for individual coverage or \$975 for family coverage (two or more dependents). Under the DGA Bronze Plan, your Deductible is \$750 for individual coverage or \$2,250 for family coverage (two or more dependents).

After you satisfy the Deductible, you pay 10% of Covered Expenses for Network claims under the DGA Premier Choice and DGA Choice Plans. Under the DGA Bronze Plan, you pay 30% of Covered Expenses. This is your Co-Insurance. When your Co-Insurance reaches \$1,000 per individual under the

DGA Premier Choice or the DGA Choice Plans and \$9,200 per individual under the DGA Bronze Plan, the Health Plan will pay 100% of Covered Expenses for the remainder of the calendar year. That means you do not have to pay any additional Co-Insurance for the rest of the year.

Under the All-Inclusive Network Out-of-Pocket Limit, you will continue to pay any Co-Payments until you reach: \$9,200 per individual and \$18,400 per family.

Currently, the only Health Plan Network Co-Payments are prescription drug Co-Payments, the \$50 emergency room Co-Payment, and the Co-Payment for care provided through the UCLA Health/EIMG clinics and related referrals.

(2) Non-Network Expenses

The Out-of-Pocket Limit for Non-Network expenses for the DGA Premier Choice Plan is \$12,500.

The Out-of-Pocket Limit for Non-Network expenses for the DGA Choice Plan is \$20,000.

There is no Out-of-Pocket Limit for Non-Network expenses for the DGA Bronze Plan.

(j) All-Inclusive Network Out-of-Pocket Limit (applies only to Network Providers)

The All-Inclusive Network Out-of-Pocket Limit is the comprehensive out-of-pocket maximum amount of Covered Expenses you are required to pay in a calendar year for services and supplies received from Network providers. This includes all Deductibles, Co-Payments and Co-Insurance paid when using Network providers. The All-Inclusive Network Out-of-Pocket Limit is separate from the Co-Insurance Maximum amount.

Section 2. Coverage Plans

The Health Plan offers several coverage plans, each with varying eligibility requirements. Generally, the plans fall into two groups:

- the DGA Premier Choice Plan and DGA Choice Plan, available to participants who meet the minimum earnings threshold of \$129,150 or \$39,820, respectively, or who are on Carry-Over Coverage or Retiree Coverage; and
- self-pay plans, available to participants on COBRA Continuation Coverage and Extended Self-Pay Coverage.

(a) DGA Premier Choice & DGA Choice Plans

The chart below (↓) provides a breakdown of eligibility requirements, your costs and benefits under the DGA Choice and DGA Premier Choice Plans.

The DGA Choice Plan and the DGA Premier Choice Plan benefits are detailed in the sections of this Summary Plan Description that describe the benefits offered by the Health Plan, beginning with the *Co-Insurance* section on page 44.

		DGA Premier Choice Plan		DGA Choice Plan	
Eligibility Requirements		<ul style="list-style-type: none"> ■ You meet the minimum earnings threshold of \$129,150; or ■ you are on Carry-Over Coverage; or ■ you are on Certified Retiree Coverage; or ■ you are on Retiree Carry-Over Coverage. 		<ul style="list-style-type: none"> ■ You meet the minimum earnings threshold of \$39,820. 	
The amounts below are applicable to Covered Expenses only.					
Calendar Year Deductible		\$325 per person; \$975 per family		\$325 per person; \$975 per family	
		Network	Non-Network	Network	Non-Network
Co-Insurance		10% of Covered Expenses	30% of Reasonable and Customary Allowed Amount for Covered Expenses	10% of Covered Expenses	40% of Reasonable and Customary Allowed Amount for Covered Expenses
Other Out-of-Pocket Costs		None	Any amount in excess of the Reasonable and Customary Allowed Amount for Covered Expenses	None	Any amount in excess of the Reasonable and Customary Allowed Amount for Covered Expenses
For Hospital emergency room services, you are also subject to a \$50 Co-Payment per visit, regardless of whether the facility is Network or Non-Network. If admitted, the Co-Payment is waived.					
Calendar Year Co-Insurance Maximum (in excess of Deductible)		\$1,000	\$12,500 per person	\$1,000 per person	\$20,000 per person
All-Inclusive Network Out-of-Pocket Limit		\$9,200 per person; \$18,400 per family	None	\$9,200 per person; \$18,400 per family	None

(b) Self-Pay Plans

The chart below (↓) provides a breakdown of eligibility requirements, your costs and benefits under each self-pay plan. The amounts below are applicable to Covered Expenses only.

	Gold Plan		Silver Plan		Bronze Plan			
	(Premier Choice Level)	(Choice Level)						
What's Covered	■ Medical ■ Prescription drugs ■ Dental ■ Vision	■ Medical ■ Prescription drugs ■ Dental ■ Vision	■ Medical ■ Prescription drugs		■ Medical			
Available if Covered Under These Plans Immediately Prior to Qualifying Event	■ Premier Choice ■ Gold (Premier level)	■ Premier Choice ■ Choice ■ Gold (Premier level) ■ Gold (Choice level)	■ Premier Choice ■ Choice ■ Gold (Premier level) ■ Gold (Choice level) ■ Silver		■ Premier Choice ■ Choice ■ Gold (Premier level) ■ Gold (Choice level) ■ Silver ■ Bronze			
What You Pay	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Co-Insurance*	Plan: 90% You: 10%	Plan: 70% You: 30%	Plan: 90% You: 10%	Plan: 60% You: 40%	Plan: 90% You: 10%	Plan: 60% You: 40%	Plan: 70% You: 30%	Plan: 50% You: 50%
Calendar Year Co-Insurance Maximum	\$1,000 per person	\$12,500 per person	\$1,000 per person	\$20,000 per person	\$1,000 per person	\$20,000 per person	\$9,200 per person \$18,400 per family	No limit
Calendar Year All-Inclusive Network Out-of-Pocket Limit	\$9,200 per person \$18,400 per family	None	\$9,200 per person \$18,400 per family	None	\$9,200 per person \$18,400 per family	None	\$9,200 per individual \$18,400 per family	None
Deductible	\$325 per person \$975 per family		\$325 per person \$975 per family		\$325 per person \$975 per family		\$750 per person \$2,250 per family	

*Co-Insurance percentages applicable to Covered Expenses only

Section 3. Network Providers

Using a Network provider benefits you in several ways, including the following:

- Network providers have agreed to charge a fixed, reduced rate, which results in a costs savings to you and to the Health Plan;
- the Health Plan pays 90% of the Allowable Charge (i.e., the covered Network charges) versus 70% (DGA Premier Choice Plan) or 60% (DGA Choice Plan) of covered Non-Network charges;
- the provider will bill the Health Plan directly;

- the provider should not bill you more than the Network negotiated rate; and
- there are strict accreditation and credentialing requirements of providers.

(a) Finding and Using Network Providers

The Health Plan has two Physician/Hospital Networks. The Network you use is dependent on where in the U.S. you receive care:

- For participants receiving care inside California, Anthem Blue Cross is the provider Network. Please use the provider finder at www.dgaplans.org/networkproviders to locate a Physician or Hospital in the Anthem Blue Cross Network.
- For participants receiving domestic care outside California, Anthem Blue Cross' BlueCard Network is the provider Network. Please use the provider finder at www.dgaplans.org/networkproviders to locate a Physician or Hospital in the Anthem BlueCard Network.

NOTE: For participants receiving care outside the U.S., please refer to Section 4(a) *Providers Outside the U.S.* on page 54.

For further assistance in locating an Anthem Blue Cross/BlueCard Network provider, call **(800) 810-2583**.

Using a Network doctor or Hospital does not necessarily mean that the treatment is covered. In addition, "approval" from the doctor, Hospital or provider Network for a certain procedure or service does not guarantee coverage under this Health Plan. For example, a non-covered service, such as Cosmetic Surgery, is not covered under the Health Plan, regardless of whether it is performed by a Network or Non-Network provider. Whether a specific procedure or treatment is covered is determined by the terms of the Health Plan. If you

have any questions about coverage, you should contact the Health Plan office for more information.

(b) Staying in the Provider Network

When you need Hospital care, you can choose a Hospital that participates in the Anthem Blue Cross (California) or Anthem BlueCard (outside California) Network. However, when you use a Network Hospital, it is important to note that all services might not be performed by Network providers. For example, the Hospital and surgeon may be Network providers, but the assistant surgeon and anesthesiologist might be Non-Network providers. A preferred provider Network is not an integrated healthcare delivery system. Providers who join a preferred provider Network do so as independent agents.

When a referral is necessary, you can ask for a referral to another Network provider. However, your doctor is not required to refer you to a Network provider, and Network providers generally have no way of accurately knowing which other providers are participating in the Network. If you wish to stay within the provider Network, you are responsible for confirming that any doctor to whom you have been referred is in the Network. Anthem will update its provider directory at least every ninety (90) days and respond to your inquiries about the Network status of a provider or facility within one business day. If you receive inaccurate information that a provider is in the Anthem Network, you will only be liable for Network Cost-Sharing.

In a non-emergency situation, it is recommended that you contact Anthem Blue Cross (California) or Anthem BlueCard (outside California) by calling **(800) 810-2583** to determine whether your referral is for a Network provider.

There is no guarantee a provider will continue to remain within the Network, as they can change at any time. It is your responsibility to make sure that the provider you are using participates within the Network at the time you receive your services.

Note that radiology, anesthesiology and pathology services provided by Non-Network providers at Network facilities are subject to Balance Billing protections.

Additionally, in instances where changes in contractual agreements result in a Provider or facility transitioning from Network to Non-Network status (excluding changes due to failure in meeting quality standards or fraud), our Plan safeguards your access to care through its Continuity of Coverage provisions.

(c) A Network Provider May Not Always Be Available

The Health Plan cannot guarantee that there will always be a Network provider available for the medical service that you need. Some areas do not have Network providers. In other areas, a Network provider in a specific field of medicine may not be available, or certain services may only be available from providers who have decided not to join the PPO Network.

When a Network provider is not available, the benefit under the Health Plan is the Non-Network benefit. However, no administrative requirements or limitations on coverage that are more restrictive than those that apply to Network Emergency Services will be imposed on Non-Network Emergency Services, non-Emergency Services from a Non-Network provider at certain Network facilities, and air ambulance services by a Non-Network provider.

Section 4. Non-Network Providers

Doctors, Hospitals and other providers that do not belong to the Health Plan's Preferred Provider Organizations (PPO) are considered Non-Network

providers. Non-Network providers may generally charge whatever they deem appropriate and balance bill you for any amount in excess of the Health Plan's maximum Allowable Charge, except with respect to Emergency Services, non-Emergency Services from a Non-Network provider at certain Network facilities, and air ambulance services by a Non-Network provider.

NON-EMERGENCY SERVICES AT A NETWORK FACILITY

Non-Emergency Services provided by Non-Network providers at certain Network facilities will be covered by the Health Plan in the same manner and with the same Cost-Sharing (*i.e.*, Co-Payment, Co-Insurance or amounts paid towards Deductibles) that applies to Network provider claims. Any Cost-Sharing payments made by the participant or beneficiary will count towards their Network Deductible, Co-Insurance Maximum and All-Inclusive Network Out-of-Pocket Limit, as applicable.

CONSENT TO BE TREATED BY A NON-PARTICIPATING PROVIDER

Notwithstanding the above, you may consent to be treated for non-Emergency Services by a Non-Network provider at a Network facility, and such services will be covered at the Non-Network level, if all the following are satisfied:

- at least 72 hours before the appointment (or three hours in advance of services rendered in the case of a same-day appointment), and on the day of the appointment, the participant or beneficiary is provided written notice: (1) that the provider is a Non-Network provider; (2) of any estimated charges for treatment; (3) of any applicable advance limitations under the Health Plan; (4) that consent to receive treatment by such Non-Network provider is voluntary; and (5) that they may instead seek care from a Network provider; and

- the participant or beneficiary gives informed consent to treatment by the Non-Network provider, acknowledging that they understand that treatment by the Non-Network provider may result in greater out-of-pocket costs compared to a Network provider.

This “notice and consent” exception does not apply to: (1) Ancillary Services; or (2) items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Network provider satisfies the notice and consent criteria. Emergency Services furnished by Non-Network providers will be covered with Cost-Sharing that is:

- no greater than the Cost-Sharing requirement that would apply if the items or services had been furnished by a Network provider;
- calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services; and
- counted toward any Network Deductible, Co-Insurance Maximum and All-Inclusive Network Out-of-Pocket Limit, as applicable, as if furnished by a Network provider.

Your Cost-Sharing amount for Emergency and non-Emergency Services at certain Network facilities by Non-Network providers will be based on the lesser of billed charges from the provider or the Qualifying Payment Amount (“QPA”).

OTHER SITUATIONS

The following chart (↓) is a breakdown of your costs when using Non-Network providers in all other situations:

Your Costs When Using Non-Network Providers			
	DGA Premier Choice	DGA Choice	DGA Bronze
Plan Pays	70% of Reasonable and Customary Allowed Amount for Covered Expenses	60% of Reasonable and Customary Allowed Amount for Covered Expenses	50% of Reasonable and Customary Allowed Amount for Covered Expenses
Participant Pays	30% of Reasonable and Customary Allowed Amount for Covered Expenses	40% of Reasonable and Customary Allowed Amount for Covered Expenses	50% of Reasonable and Customary Allowed Amount for Covered Expenses
Other Out-of-Pocket Charges	You pay any amount in excess of the Reasonable and Customary Allowed Amount		
	<p>Note: Emergency Services, non-Emergency Services from Non-Network providers at certain Network facilities, and air ambulance services by Non-Network providers will be covered by the Health Plan in the same manner and with the same Cost-Sharing (i.e., Co-Payment, Co-Insurance or amounts paid towards Deductibles) that applies to Network provider claims.</p>		

Health Plan benefits apply only to Covered Expenses up to an amount that the Plan determines is the maximum Allowable Charge for the service provided.

A Reasonable and Customary Allowed Amount, commonly referred to as “R&C,” only applies to Non-Network claims, other than Non-Network Emergency Services, Emergency or non-Emergency Services from a Non-Network provider at certain Network facilities, and Non-Network air ambulance services.

A Reasonable and Customary Allowed Amount is a charge or fee that is equal to the lesser of: (1) actual billed charges; (2) 150% of the applicable Medicare reimbursement rate for a specified procedure; or (3) in the event there is no Medicare reimbursement rate for a specified procedure or it cannot be determined based on the information submitted, the amount that would be paid to a similar provider for the same or similar service or item in the same geographic location or locality. Schedules of maximum Reasonable and Customary Allowed Amounts are adjusted periodically to reflect changes in Physicians’ charges.

The Health Plan’s Allowable Charge for any medical procedure or service from a Non-Network provider will not exceed the applicable Reasonable and Customary Allowed Amount noted above.

When you use a Non-Network provider, you are responsible for any charges in excess of the maximum Allowable Charge and all non-Covered Expenses, except with respect to Emergency Services, non-Emergency Services received from a Non-Network provider at certain Network facilities, and air ambulance services furnished by Non-Network providers.

(a) Providers Outside the U.S.

Generally, doctors outside of the United States are considered Non-Network providers. Doctors outside

the U.S. will generally bill you directly for their services.

For further assistance, contact the Blue Cross Blue Shield Global Core program at **(800) 810-2583** for the following:

- help finding a provider or Hospital outside the U.S. that will bill the Health Plan directly for your services;
- if you are traveling outside the U.S. and need to locate a doctor or Hospital; or
- if you need medical assistance services or pre-authorization for inpatient care.

ADDITIONAL CONSIDERATIONS WHEN SEEKING CARE OUTSIDE THE U.S.

- You are responsible for obtaining any pre-authorizations required under Health Plan rules. For information on when pre-authorization is required, refer to the section titled *Hospital* on page 68.
- When traveling outside the U.S., always carry your Health Plan ID card.
- For more information about the Blue Cross Blue Shield Global Core program and general tips for accessing your medical benefits while abroad, go to www.dgaplans.org/travelingabroad.

Section 5. Coordination of Benefits

In many families, both spouses work. Each may be covered by a group health plan, and each may include the other and/or their children as dependents.

Coordination of Benefits refers to the set of rules that determines responsibility for payment among all health plans that cover an individual. Eligible charges include all types of care covered under at

least one of the plans. The Health Plan coordinates benefits with the following types of other coverage:

- group insurance coverage;
- private (individual, non-group) insurance coverage;
- government-provided programs (such as Medicare);
- coverage provided by statute;
- Employer-sponsored coverage; and
- any coverage under labor-management trusted plans.

During your Open Enrollment Period, you will be sent a Coordination of Benefits form. You must fill out the form each Benefit Period, even if you completed one before and your information has not changed. The Health Plan will not pay your claims without an updated form for each Benefit Period. To ensure your claims continue to be paid without delay, please complete and return this form as soon as possible.

You must also submit this form if at any point you or your dependents' coverage with another insurer changes or terminates, even if such a change occurs in the middle of your Benefit Period. In cases of coverage termination, you must submit a copy of the termination notice from the other insurer along with a new Coordination of Benefits form.

(a) General Rules

The first of the following rules that applies to your specific situation is used to determine which plan is primary, secondary, tertiary, etc.:

- the plan without a coordination of benefits provision is always primary;
- the plan covering you as a participant is primary to the plan covering you as a dependent, with one exception: In the case

when you have Inactive Coverage with this Health Plan and are also a Medicare recipient and are covered as a dependent by a working spouse, the plan which covers you as the dependent of a working spouse is primary, Medicare is secondary, and your own Inactive Coverage with this Plan is tertiary. For more information on Medicare, see the section titled *Medicare and Plan Benefits* beginning on page 58;

- the plan covering you as an active employee is primary to any plan covering you as an inactive, laid-off, self-pay or retired employee; and
- if you have the same type of coverage (*i.e.*, Active, COBRA, self-pay, etc.) with more than one plan, the plan with 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.

If you are eligible for group health benefits and are required to pay a premium but decline to pay the premium, and then at a later date begin to pay the premium, the period during which the premium was unpaid does not constitute a break in eligibility for the purpose of determining the plan that you have with the longest continuous eligibility.

(b) Rules for Dependent Children

1. The first of the following rules that applies to the dependent child's situation is used to determine which plan is primary:
 - a. The plan covering a person as a participant is primary to the plan covering the person as a dependent.
 - b. If the claim is for a dependent child, the plan of the parent whose birthday occurs earlier in the calendar year is primary. This is called the "Birthday Rule."

- c. If both parents have the same birthday, the plan which covered the parent longer is primary.
2. If the claim is for a dependent child of divorced or separated parents, the first of the following rules that applies to the dependent child's situation is used to determine which plan is primary:
 - a. If a court order and judgment provides a specific coordination of benefits order, the court order will be followed. A copy of the court order or judgment for both situations is required by the Health Plan. Notwithstanding the foregoing, this section shall not apply to any periods or Plan Years during which any benefits were paid or provided before the Health Plan had actual knowledge of the specific terms of any applicable court order or judgment.
 - b. If the specific terms of the court order or judgment states that both parents are responsible for the dependent child's healthcare expenses, the Health Plan shall coordinate benefits in the same order as (1)(b).
 - c. If there is no court order or judgment allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the Health Plan shall coordinate benefits in the following order:
 - i) the plan covering the custodial parent pays first;
 - ii) the plan of the spouse of the custodial parent pays second;
 - iii) the plan of the non-custodial parent pays third; and
 - iv) the plan of the spouse of the non-custodial parent pays fourth.
3. For any dependent children covered under more than one plan of individuals who are not the child's legal parent or legal guardian, the plan of the individual with custody is primary; the plan of the custodial individual's spouse (if any) is secondary; the plan of any individual (if any) without custody is tertiary; and the plan of the spouse of the non-custodial individual (if any) will pay quaternary.

(c) Payment of Coordinated Claims

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

- 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; or
- 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 greater of the allowable amount and the amount paid by the primary plan, but not to exceed the amount the Health Plan would have paid as if it was primary.

For an example, refer to the graphic on the next page (↗).

(d) Dependent Premium and Coordination of Benefits

When both a participant and spouse 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 participant and spouse are covered as participants under their own coverage but will not be covered as a dependent under their respective spouse's



How It Works:

Payment of Coordinated Claims

Jane's Treatment

Jane has health coverage under both the DGA-Producer Health Plan and a private insurance plan. She incurs a medical claim totaling \$500. The charts below shows how the DGA-Producer Health Plan pays benefits on her claim, depending on whether the Health Plan is primary or secondary.

1 If the Health Plan is primary

Allowable Charge	\$500
The Health Plan pays (90%)	\$450
Jane pays (10%)	\$50

2 If the Health Plan is secondary

Allowable Charge	\$500
Jane's primary plan pays	\$400
The Health Plan pays	\$100
Jane pays	\$0

**The example above assumes Jane was treated by a Network provider and that she has satisfied her annual Deductible.*

coverage, and there will be no coordination of benefits. If both participant and spouse 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. In addition, any dependent children will be covered under the health coverage of both parents and will receive full coordination of benefits. The coverage of the participant whose birthday falls earlier in the year will be considered primary. The coverage of the other participant will be considered secondary. If both participants have the same birthday, the coverage of the parent that has been covered for a longer period of time under the Health Plan will be considered primary.

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. In addition, any dependent children will be covered only under the health coverage of the spouse that paid the dependent premium and will receive no coordination of benefits.

(e) Coordination of Benefits with Other Entertainment Industry Health Plans

If you or your dependents are eligible for Earned Active primary coverage with another entertainment industry health plan that requires a premium and you or your dependent fails to pay or declines to pay the premium in that plan, the Health Plan will maintain its secondary position. This means that for Hospital and major medical benefits, the Health Plan will calculate the benefit

payable at 20% of the Allowable Charge, subject to Deductibles and Co-Payments, if any. This rule serves to maintain the correct primary/secondary positions of the Health Plan based on the longest continuous coverage.

(f) Coordination of Benefits with HMOs, EPOs, POS and Other Health-Managed Organization Plans

If you or your dependents have primary coverage with a Health Maintenance Organization (“HMO”), Exclusive Provider Organization (“EPO”), Point of Service Organization (“POS”) or other plan with the combined elements of both HMO and PPO plans, and you do not use the Network providers through your primary plan (HMO, EPO, POS or other health managed organization plan), the Health Plan will require a copy of their Explanation of Benefits showing that the services were not covered. The Health Plan would then become the primary payer for those services.

Section 6. Medicare and Plan Benefits

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

(a) Medicare Part A, Part B and Part D

Medicare Part A, which covers hospitalization and certain follow-up services, is generally free of charge to eligible retirees. Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

Medicare Part B, which helps pay doctor bills and other medical bills, requires a monthly premium.

In order for you to receive optimum coverage and reimbursement for your Hospital and doctor bills when Medicare is your primary insurance coverage, it is important that you enroll in both Medicare Part A and Part B. If you and/or your spouse are eligible for Medicare and fail to enroll in both 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 have received reimbursement for your medical expenses from Medicare.

Medicare Part D covers prescription drugs. If you are covered under the Health Plan’s prescription drug coverage, you do not have to enroll in Medicare Part D. If you are not covered under Earned Coverage and choose to enroll in Medicare Part D, you will not be eligible for the Health Plan’s prescription drug coverage. If you elect not to enroll in Medicare Part D while you are covered under the Health Plan’s prescription drug coverage, you will not be adversely affected if you choose to switch to Medicare Part D in the future.

(b) Participants on Active Coverage

As no premium is due for Medicare Part A (in most cases), Medicare-eligible participants should enroll in Medicare Part A when they become eligible.

Medicare-eligible participants on Earned Active Coverage do not need to enroll in Medicare Part B. However, you need to ensure that your Medicare Part B coverage starts when your Active Coverage with the Health Plan ends. This typically means signing up for Medicare no later than 60 days before your Earned Coverage is scheduled to expire. See the *Coordination of Benefits with Medicare* section on page 59 for more information.

(c) Participants on Inactive Coverage

If you are on Inactive Coverage and are also Medicare-eligible, you must enroll in both Medicare

Parts A and B to receive full reimbursement for your Hospital and doctor bills. While coverage under Medicare Parts A and B will generally not begin until you turn 65, you must enroll in Medicare prior to your 65th birthday in order for Medicare Part A and Medicare Part B coverage to be in effect on your 65th birthday. This is the only way to insure full reimbursement for your Hospital and doctor bills when Medicare is your primary insurance coverage.

You do not need to enroll in Medicare Part D, Medicare's prescription drug program, as long as you are covered under the Health Plan's prescription drug program. If you decide to enroll in Medicare Part D, you will not be eligible for the Health Plan's prescription drug benefit, unless the participant is covered under Earned Coverage. An actuary hired by the Health Plan has determined that the Health Plan's prescription drug benefit is actuarially equal to, or better than, the standard Medicare Part D prescription drug benefit. Please note the Health Plan's Bronze Plan does not provide prescription coverage.

For Medicare-eligible participants, 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 and the amount payable by the Health Plan. To receive full reimbursement for your Hospital and doctor bills, you must enroll in Medicare Parts A and B. Otherwise, the Health Plan will calculate the benefit payable at 20% of the Allowable Charge, subject to Deductible and Co-Payment, if any.

(d) Coordination of Benefits with Medicare

(1) Active and Inactive Participants

Federal law requires that the Health Plan be primary to Medicare for Active participants. The type of Covered 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:

- If you have Covered Earnings for covered employment (current employment or non-residuals) that meet or exceed the minimum earnings threshold for eligibility, you are considered an Active participant, and the Health Plan is the primary payor.
- If you have Covered Earnings solely from residuals that meet or exceed the minimum earnings threshold for eligibility, or if you have used Carry-Over Credit to maintain Earned Coverage, you are considered Inactive, and Medicare is the primary payor.
- If your Covered Earnings comprise both current employment and residuals but are less than the amount required to meet the minimum earnings threshold for eligibility from current employment, you are considered Inactive, and Medicare is the primary payor.

The minimum earnings threshold is periodically reviewed by the Board of Trustees. The current minimum earnings threshold is published on an annual basis in the *Spotlight on Benefits* newsletter and on www.dgaplans.org. You may also call the Health Plan.

If you have health coverage under Medicare and under another plan that supersedes Health Plan coverage under the coordination of benefits rules (see the section titled *Coordination of Benefits* beginning on page 54 for more information), then the Health Plan may be tertiary, rather than secondary. In addition, if you have end stage renal disease and are covered by Medicare, different rules may apply. Please call the Health Plan for more information.

(2) Retired Participants

Medicare is considered primary, and the Health Plan is secondary for retired Medicare-eligible

participants and their Medicare-eligible spouses not covered under Earned Active Coverage.

Medicare becomes primary on the first day of the month in which you or your spouse turns 65. If you or your spouse's birth date is on the first of the month, Medicare becomes effective on the first of the prior month. All benefits will be coordinated with Medicare Parts A and B.

If you retire and then return to work and requalify for Earned Active Coverage, you and any 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 your spouse if you do not pay the dependent premium.

If the provider does not submit your claim to the Health Plan on your behalf, you will need to submit a copy of your itemized bill, along with the Explanation of Benefits sent to you by Medicare, to the Health Plan. Make sure your name and Health Plan ID number are on the form.

(e) Doctors Who Do Not Participate in Medicare

If you are a Medicare-eligible retiree and choose to use a non-Medicare participating provider, you will have substantially higher medical costs. If you go to a doctor who does not participate in Medicare or has opted out of Medicare, and Medicare is your primary plan, the Health Plan will cover you as if Medicare is primary. That means, for most procedures, the Health Plan will pay 20% of the Allowable Charge, subject to Deductible and Co-Payments, if any.

Section 7. UCLA Health Centers/Entertainment Industry Medical Group (EIMG)

In addition to the Health Plan's already robust medical benefits, if you are in the Los Angeles area, you may also enjoy access to four University

of California, Los Angeles/Entertainment Industry Medical Group (UCLA/EIMG) Health Centers, which exclusively serves the entertainment community.

By coordinating your care through the UCLA/EIMG Health Centers, you get quality services at a reduced cost. These benefits are not available under the DGA Bronze Plan. For questions about referrals or services provided from these health centers, please contact the UCLA Industry Health Network customer service at **(800) 876-8320**.

You may use any of the following UCLA/EIMG offices:

- Hollywood Primary Care (formerly Bob Hope)
335 N. La Brea Avenue
Los Angeles, California 90036
(323) 634-3850
Monday – Friday: 8:00 a.m. - 5:00 p.m.
www.uclahealth.org/locations/hollywood-primary-care
- Calabasas Primary & Specialty Care
26585 W. Agoura Road
Suite 330
Calabasas, California 91302
(818) 876-1050
Monday - Friday: 8:00 a.m. - 5:00 p.m.
www.uclahealth.org/calabasas
- Santa Clarita 23861 McBean Primary Care
23861 McBean Parkway
Suite E-24
Valencia, California 91355
(661) 284-3100
Monday - Friday: 8:00 a.m. - 5:00 p.m.
www.uclahealth.org/schc
- Toluca Lake Primary Care
4323 Riverside Drive
Burbank, California 91505
(818) 556-2700
Monday - Friday: 7:00 a.m. - 8:00 p.m.
Weekends and Holidays: 9:00 a.m. - 6:00 p.m.
Open 365 days/year
www.uclahealth.org/toluca-lake

- Westside Primary Care
1950 Sawtelle Boulevard
Suite 130
Los Angeles, California 90025
(310) 996-9355
Monday - Friday 8:00 a.m. - 5:00 p.m.
www.uclahealth.org/westside

For a schedule of applicable Co-Payments and Co-Insurance, see the chart below (↓). Services rendered or referred through the UCLA/EIMG Network are not subject to the Health Plan's annual Deductible.

In order to receive the benefits through UCLA/EIMG, you need to make an appointment at one of the UCLA/EIMG offices in this section to see a primary care Physician ("PCP"). The PCP will then monitor your care and make any necessary referrals to specialists or Ancillary Services (laboratory, radiology, etc.). Referrals at one of these health centers will have the same Co-Payment. Without the PCP's referral, the UCLA/EIMG level of benefits will not apply. You do not need prior authorization or referral from any person, including your PCP, to obtain access to obstetrics or gynecological care.

In order to receive services through the UCLA/EIMG Health Centers, your dependent child must be at least 13 years of age. For children under 13, you can obtain a UCLA/EIMG referral to a pediatrician by calling the UCLA/EIMG customer service at **(800) 876-8320**.

In addition, UCLA Health contracts with the following Southern California Hospitals for inpatient care and outpatient support:

- Cedars-Sinai Medical Center – Los Angeles
- Henry Mayo Newhall Memorial Hospital – Valencia
- Los Robles Hospital and Medical Center – Thousand Oaks
- Olympia Medical Center – Los Angeles
- Providence Holy Cross Medical Center – Mission Hills

- Providence Saint Joseph Medical Center – Burbank
- Providence Tarzana Medical Center - Tarzana
- Ronald Reagan UCLA Medical Center – Los Angeles
- Saint John's Hospital and Health Center – Santa Monica
- UCLA Medical Center – Santa Monica
- West Hills Hospital & Medical Center – West Hills

(a) Payment Schedule

The chart below (↓) details the Co-Payment and Co-Insurance for benefits received through a UCLA/EIMG PCP at one of the facilities listed beginning on page 60.

UCLA Health Centers/EIMG Payment Schedule	Covered Patient's Co-Payments
Primary Care Visits	\$10
Visits to Specialists*	\$10
Physical Therapy **	\$10
Durable Medical Equipment* (Amount paid for rental will not exceed the purchase price)	\$0
Lab Tests/Radiology*	\$0
Hospital Outpatient*	10%
Surgery*	\$100
Anesthesia*	\$0
Comprehensive Physical Exam	\$0
Well Child Care/Pediatric Visits	\$10
Preventive Services Pursuant to the Affordable Care Act	\$0
Picture Quitting (Smoking cessation program)	\$0

*A written referral from the primary care Physician is required, and a referral number will be required when the claim is submitted to the Health Plan.

**The Physical Therapy benefit is limited to \$85 allowable per visit.

(b) Free Comprehensive Physical Exam

An often overlooked benefit of both the DGA Choice Plan and the DGA Premier Choice Plan is the free comprehensive physical exam offered through the UCLA/EIMG offices listed beginning on page 60.

There is no Deductible or Co-Payment for this benefit for you and your covered dependents under the following circumstances:

- If you and/or your covered dependents are over age 40 and use one of the UCLA/EIMG offices, you and/or your covered dependents can receive a physical exam once every calendar year.
- For you and/or your covered dependents age 19 to 40, the exam at one of the UCLA/EIMG offices is provided once every two calendar years.

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.

Afterward, your Physician will review the results of the examination with you and provide 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 UCLA/EIMG offices listed beginning on page 60 for an appointment.

Section 8. Pre-Determination and Pre-Authorization of Benefits

The Health Plan covers Medically Necessary visits, treatments and procedures for you and your eligible dependents. One of the Health Plan's criteria for determining Medical Necessity includes whether the procedure or service is consistent with generally accepted medical guidelines and practices, which may require that certain treatment options be administered prior to or instead of others. When standard medical practice is not followed, a treatment will be deemed not Medically Necessary and, therefore, will not be covered under the Health Plan.

If you are uncertain about whether a treatment or procedure is Medically Necessary, you should request a voluntary pre-determination from the Health Plan before receiving the service. A pre-determination is a written analysis, provided by the Health Plan upon request, which evaluates the Medical Necessity of a particular procedure or treatment before you receive it. A pre-determination will provide you with information on how the Health Plan might apply benefits for the service in question; however, it does not guarantee coverage. A final determination of coverage can be made only after the procedure has been performed, upon processing the claim, and reviewing additional information and records submitted.

A pre-determination is not the same as a pre-authorization. Pre-determination is a voluntary request for information from the Health Plan. Pre-authorization, on the other hand, is a required step your provider must take to confirm Health Plan coverage for certain services, including inpatient Hospital stays, mental health and substance abuse intensive outpatient treatment, certain prescriptions drugs, partial hospitalization, and residential care. In contrast to pre-determination, pre-authorization guarantees that the authorized procedures will be covered.

To start the pre-determination process, you or your provider should submit all of the items below to the Health Plan's Claims Department via fax at **(323) 782-9287** or email at **hpclaims@dgaplays.org**:

- your medical records;
- a letter of Medical Necessity from your provider, including all diagnoses and procedure codes for the services being considered; and
- an office contact at the provider's office.

Failure to submit all of the information noted above may delay the Health Plan's review of your pre-determination request. Depending on the type of service in question, your pre-determination may be sent to a third party to conduct an independent medical review.

Following receipt of your request, the Health Plan will send you or your provider a written response outlining the results of the pre-determination of Medical Necessity for each procedure code. The pre-determination will indicate whether a particular procedure code reflects Medical Necessity; it is not a guarantee of coverage for the procedure.

Section 9. What's Covered Under Medical Benefits

The Health Plan's medical benefits cover 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.

All of the Health Plan's benefits, as described in this section, are applicable whether or not the condition that is being treated existed prior to the time you were covered by the Health Plan.

All care must be Medically Necessary, excluding covered preventive care services. If you are uncertain about whether a treatment or procedure

is Medically Necessary, you should request a voluntary pre-determination from the Health Plan before receiving the service. Please refer to the section titled *Pre-Determination and Pre-Authorization of Benefits* on page 62 and the definition of Medically Necessary in the Glossary of this Summary Plan Description on page 136 for more details.

(a) Acupuncture

Acupuncture is covered subject to the following terms:

- Acupuncture is covered up to 20 visits per individual per calendar year.
- The maximum Allowable Charge for Acupuncture treatment is \$85 per visit.
- Multiple treatments in one day by the same provider are treated as one visit and are subject to the maximum Allowable Charge of \$85.
- Lab, X-ray and other diagnostic testing will not be covered when ordered by a licensed acupuncturist (whether designated by that term or by another term such as "Oriental Medical Doctor"), even if the testing is performed by a Physician.

(b) Ambulance Service

Licensed ambulance company service is covered when Medically Necessary for:

- emergency ground transportation to a local Hospital;
- local ground ambulance transport from a Hospital to home at discharge when transport by non-ambulance is impossible or the patient's health would be seriously jeopardized if an ambulance was not used; or
- local ground ambulance transport to and from a separate facility for Medically Necessary

diagnostic/treatment services during inpatient Hospital confinement.

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 Medically Necessary services.

The determination of the nearest facility equipped to provide the necessary services is up to the sole discretion of the Health Plan and the Board of Trustees. Pre-authorization at a specific facility does not mean that the facility has been, or will be, determined to be the nearest facility equipped to provide necessary services and does not guarantee that air transportation (*e.g.*, air ambulance) to that facility will be covered by the Health Plan.

For air ambulance services, coverage is limited to three times in your lifetime or your eligible dependent's lifetime. Ground ambulance services are not considered "Emergency Services" for purposes of the Health Plan and as that term is defined in the section titled *Emergency Services* on page 66. That means you will be responsible for any amounts billed by Non-Network ground ambulance providers above the Reasonable and Customary Allowed Amount and any applicable Cost-Sharing (*i.e.*, Co-payments, Co-Insurance and Deductibles).

Ground and air ambulance transportation for patient or doctor convenience is not covered.

(c) Ambulatory Surgical Center

Non-Network Ambulatory Surgical Center charges will be reimbursed up to a maximum Allowable Charge of \$1,500 per participant per calendar year, if all of the conditions for coverage described here are met. If the actual charge is less than \$1,500,

the Allowable Charge will be the actual charge. Any applicable Deductibles and Co-Insurance will apply.

An Ambulatory Surgical Center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures and must be Medicare-certified or state-licensed as an Ambulatory Surgical Facility or have certification from a private accreditation agency accepted by the state in lieu of state licensure.

The type of procedures performed must permit discharge from the center on the same working day.

(d) Birthing Center

A birthing center is a facility established to manage low risk, normal, uncomplicated pregnancies with delivery expected 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:

- prenatal 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; and
- services of a Midwife under the supervision of a medical doctor.

(e) Case Management

Case management is a voluntary process included in your Health Plan in which a case management coordinator works with the patient, the family and the attending Physician to help determine that you and eligible dependents are receiving appropriate

treatment when medical care is necessary for a catastrophic or chronic Sickness or injury. 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, AIDS and certain mental health and substance use disorder conditions.

If you agree to case management, the Health Plan may, at its discretion, decide to pay for certain benefits as alternatives to traditional inpatient care that would not otherwise be covered under the Health Plan, if it determines, in its sole discretion, that providing such coverage will save the Health Plan from covering other more expensive treatments.

If an alternative treatment plan to traditional inpatient care is suggested by the case management coordinator, such alternative treatment plan will not be covered unless the Health Plan, as well as you and the Physician, agree to the alternative plan.

The purpose of the case management program is to benefit the patient. If you or the Physician do not think the alternative treatment is beneficial, you do not have to participate.

Case management may also be requested to assist you before a claim is submitted in determining whether certain proposed outpatient services (which do not require pre-authorization) will be considered Medically Necessary, such as extensive home nursing visits or participation in a cognitive rehabilitation program after a stroke or traumatic brain injury.

All requests for case management must be approved by Anthem Blue Cross' case management services and the Health Plan. For information on case management, please contact the Health Plan office.

(f) 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.

The Health Plan will allow one office visit for the evaluation and management of a new patient, which will not be included in the 20-visit limit and not subject to the \$50 maximum Allowable Charge. Payment will be based on Network rates or Reasonable and Customary Allowed Amounts.

Multiple treatments in one day by the same provider are treated as one visit and subject to the maximum Allowable Charge of \$50. All services rendered by a chiropractor must be consistent with the scope of his or her license. Additionally, the following services are not covered when rendered or requested by a chiropractor:

- care of conditions other than musculoskeletal disorders;
- treatment of the feet, including diagnostic X-rays;
- foot orthotics;
- studio or on-site calls, home visits or exercise at a gym or similar facility;
- all diagnostic tests except for musculoskeletal X-rays even if such tests are administered or interpreted by a medical doctor; or
- Chiropractic Care for a child younger than five years of age.

(g) Contraception

All forms of FDA-approved contraception are covered by the Health Plan. Some forms (such as vasectomies and tubal ligations) are covered under medical benefits, and others (such as birth control pills) are covered under prescription drug benefits. The Health Plan covers at least one form of contraception in each category identified by the Health Resources & Services Administration ("HSRA") supported guidelines at 100% without Cost-Sharing. Only generic contraceptives will be

covered at 100%. However, if a healthcare provider determines a specific brand-name contraceptive is Medically Necessary, and no generic equivalent is available or medically appropriate, the Health Plan will cover the brand-name contraceptive at 100% without Cost-Sharing. For additional details on coverage, see the section titled *Prescription Drug Benefits* beginning on page 83. This coverage includes, but is not limited to, the following:

- Norplant is covered under the medical or prescription drug benefits. These devices are covered under the prescription drug benefits if purchased at a pharmacy. Otherwise, they are covered under medical benefits;
- vasectomies and tubal ligations are covered under medical benefits; and
- diaphragms and birth control pills are covered under prescription drug benefits.

In addition, the Health Plan covers any FDA-approved, cleared, or granted contraceptive product or service deemed Medically Necessary by a healthcare provider, regardless of whether it is listed in the HRSA-supported guidelines' categories, ensuring comprehensive contraceptive care for participants. This coverage also includes clinical services, including patient education and counseling, needed for the provision of the contraceptive product or service.

(h) Cosmetic Surgery

Cosmetic Surgeries and related charges are only considered Covered Expenses when:

- reconstructive surgery is performed to correct a deformity created by previous, non-Cosmetic Surgery;
- reconstructive surgery is performed to correct a deformity resulting from Accidental bodily injury; or
- reconstructive surgery is performed to correct a congenital deformity.

Notwithstanding the foregoing, the Health Plan provides medical and surgical benefits for certain types of reconstructive surgery in connection with a mastectomy. See section titled *Women's Health and Cancer Rights Act of 1998* on page 123 for more information.

(i) Emergency Services

Emergency Services means the following:

- an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and
- within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

Emergency Services include post-stabilization services furnished by a Non-Network provider or Non-Network Emergency Facility as part of outpatient observation or an inpatient/outpatient stay related to the emergency medical condition (regardless of the department of the Hospital in which such items or services are furnished), until:

- the provider or facility determines that the participant or beneficiary is able to travel using non-medical transportation or non-emergency medical transportation;
- the participant or beneficiary is supplied with appropriate written notice: (1) that the provider is a Non-Network provider; (2) of any estimated charges for treatment; (3) of any applicable advance limitations under

the Health Plan; (4) that consent to receive treatment by such Non-Network provider is voluntary; and (5) that they may instead seek care from a Network provider; and

- the participant or beneficiary gives informed consent to continued treatment by the Non-Network provider, acknowledging that continued treatment by the Non-Network provider may result in greater cost to the participant or beneficiary.

Emergency Services include those provided in Hospital emergency room departments, Independent Freestanding Emergency Departments and some post-stabilization services. Pre-authorization is not required for any Emergency Services. You will be responsible for the same Cost-Sharing (*i.e.*, Co-Payments, Co-Insurance and Deductibles) for Hospital emergency room services regardless of whether you obtain those services from a participating Network provider or from a Non-Network provider. Accordingly, Emergency Services provided in an emergency room by a Non-Network provider will be covered at the Network Co-Insurance level (*i.e.*, 90% for the DGA Premier Choice and DGA Choice Plans and 70% for the DGA Bronze Plan), subject to the Health Plan's \$50 per visit emergency room Co-Payment and annual Deductible. The Co-Payment is waived if admitted.

If you receive Emergency Services from a Non-Network Hospital or provider, Emergency or non-Emergency Services from a Non-Network provider at certain Network facilities, or air ambulance services from a Non-Network provider, they may not bill you separately if their charges exceed the Health Plan's Covered Expenses, and you will pay the same Cost-Sharing as Network claims.

Ground ambulance services are not considered "Emergency Services" for purposes of the Health Plan and as that term is defined in this section. That means you will be responsible for any amounts billed by Non-Network ground ambulance providers

above the Reasonable and Customary Allowed Amount and any applicable Cost-Sharing (*i.e.*, Co-Payments, Co-Insurance and Deductibles).

(j) Foot Orthotics

Custom-molded foot orthotics are covered:

- once every 12 months for dependents age 16 and under; and
- once every 24 months for you or your dependents over age 16.

(k) Hearing Aids

Hearing aids (not including batteries) are covered up to a \$1,500 annual cap. The \$1,500 cap is applied per person, per calendar year (not per device).

(l) Hospice Care

Hospice care is an interdisciplinary program of supportive services that address the physical, spiritual, social and economic needs of the Terminally Ill patient and the patient's 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 patient's impending death. Hospice care also includes bereavement counseling for the immediate family.

The Health Plan covers Hospice care for you and your eligible dependents if you are Terminally Ill. Hospice care can be provided at home or at an inpatient Hospice facility. To be covered, Hospice care must:

- provide 24-hour, 7-days-a-week service;
- provide a program of services under direct supervision of a Physician or licensed RN;
- maintain full and complete records of all services provided; and
- be established and operated in accordance with the applicable laws and regulations, including of its local jurisdiction.

For the patient, the following is covered under Hospice care, in addition to what's covered under the Health 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; and
- 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.

The following Hospice care benefits are payable for the immediate family of the patient:

- charges for respite care provided in the home or on an inpatient 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.

Note: The Health Plan provides Palliative Care benefits through Motion Picture Trust Fund. To enroll or to learn if Palliative Care is right for you, call **(818) 876-1739**.

(m) Hospital

The Health Plan provides coverage for the following Hospital care and services when approved as Medically Necessary through utilization review (pre-authorization) by Anthem Blue Cross:

- 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 service; or
- use of operating rooms.

There is an additional \$500 Co-Payment per admission for admission to a Non-Network Hospital.

This \$500 Co-Payment does not count towards the annual Out-of-Pocket Limit. This \$500 Non-Network Hospital Co-Payment is waived if you are admitted while receiving Emergency Services, or if you live or work more than 30 miles from a Network Hospital.

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.

For utilization review (pre-authorization) of inpatient Hospital admissions in the U.S., providers should call Anthem Blue Cross at **(800) 274-7767**.

For utilization review of inpatient Hospital admissions outside the U.S., providers should call Blue Cross Blue Shield Global Core at **(800) 810-2583**.

(n) Infertility

The Health Plan's Infertility benefit is administered by Carrot. For additional information, visit www.dgaplans.org/infertilitybenefits.

The Health Plan provides coverage for Medically Necessary Infertility treatment with a medical diagnosis of Infertility. For all Health Plan purposes, the term "Infertility" shall be defined as set forth in the Glossary on page 135.

Examples of covered Infertility treatment include, among others:

- Infertility consultations;
- semen analysis;
- short-term fertility preservation for males and females (for example, short-term egg freezing or semen freezing if scheduled to undergo a procedure that may result in loss of fertility, such as radiation or chemotherapy);
- genetic testing related to Infertility;
- intrauterine insemination;
- in vitro fertilization; transportation of reproductive material with an approved vendor;
- short-term storage costs for eggs, sperm, and/or embryos; and
- Infertility medications.

Examples of non-covered Infertility treatment include, among others:

- any Infertility treatment provided by a non-Carrot provider;
- any Infertility treatment without a medical diagnosis of Infertility;
- long-term Infertility preservation, including egg or sperm freezing;
- expenses related to surrogacy or adoption;
- Infertility related treatments under the care of primary care providers or OB/GYNs;
- herbal treatments;
- nutrition counseling;
- general genetic tests; and
- Physical Therapy or fitness related expenses.

An eligible participant and their dependent spouse, if any, may each receive up to a total lifetime maximum benefit of \$30,000 for Infertility

treatment. The \$30,000 lifetime maximum benefit is an aggregate total of all covered services received from all Carrot providers.

The Infertility treatment benefit is only available to participants and their covered dependent spouses, if any, who have Earned Active Coverage, Earned Inactive Coverage, Carry-Over Coverage or related COBRA Coverage.

The Infertility treatment benefit is not available to dependent children or any participant or beneficiary on Certified Retiree Coverage, Retiree Carry-Over Coverage or Extended Self-Pay Coverage.

Infertility treatment coverage is provided without application of Deductibles, Co-Payment or Co-Insurance.

For all Health Plan purposes, 'short-term' shall mean up to a maximum of one year, and 'long term' shall mean one year or longer.

Infertility treatment must be received from Carrot providers in order to be eligible for coverage by the Health Plan. Infertility treatment received from any provider that is not a Carrot provider is not covered by the Health Plan. You are responsible for paying any Infertility treatments and services not covered by the Health Plan. Participants can find Carrot providers and schedule appointments through Carrot's website portal at: www.get-carrot.com.

Carrot will provide coverage through a pre-funded debit card, which you will be able to use to pay Carrot providers for up to \$30,000 in eligible expenses. You are responsible for submitting all other claims for covered services directly to Carrot for reimbursement at: www.get-carrot.com. See the section titled *Filing a Claim* on page 101 for more information.

The Health Plan's benefit for Infertility treatment is effective July 1, 2022. Any Infertility claims incurred prior to such date are not covered.

(o) Injected/Infused Drugs

Many self-administered or clinician-administered infusion therapies are covered when obtained through CVS Specialty. Refer to the section titled *Specialty Drugs* on page 87 for additional information.

(p) Laboratory and Diagnostic Tests and Services

The Health Plan covers Medically Necessary laboratory and diagnostic tests and services ordered by a Physician to treat Sickness or injury.

(q) Maternity Care

Maternity care benefits are provided for you and your dependent spouse only. Maternity care is not provided to dependent children, except for:

- preventive care services as mandated by the Affordable Care Act; and
- if an eligible dependent child has Complications of Pregnancy, services directly related to the Complications of Pregnancy shall be covered, and the newborn child shall be covered for the first 31 days after birth.

In compliance with the Newborns' 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. These applicable 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 following a vaginal delivery or earlier than 96 hours following a 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 up to 48 hours following vaginal delivery (or 96 hours following a cesarean section).

Notwithstanding the foregoing, the Health Plan will cover services for you, your dependent spouse or dependent child incurred in connection with the termination of a pregnancy for any reason. In addition, the Health Plan will cover travel, lodging and related medical expenses for you, your dependent spouse or your dependent child, and one other family member or support companion, when travel is necessary because termination of a pregnancy is not legally available in the state of residence or, if applicable, not legally available in the state in which you are currently employed or engaged in covered employment. Reimbursement will be provided subject to the following additional conditions and limitations:

TRANSPORTATION

- The Health Plan will only reimburse necessary travel expenses to: (a) the individual's state of residence; or (b) the nearest state where specified services are legally available;
- reimbursement is available for 100% of the actual cost for round trip "coach" airfare;
- reimbursement is available for 100% of the actual cost for travel via trains, subways, buses, taxis, ride shares or other public transportation; and
- mileage reimbursement is available for use of a personal vehicle at the applicable rate set forth by the Internal Revenue Service and updated from time to time (e.g., 0.700 cents/mile in 2025).

LODGING

- The Health Plan will reimburse reasonable lodging expenses when travel is necessary to receive the specified services;
- Lodging must be for, and in connection with, the specified services and not for personal pleasure, recreation or vacation;
- Lodging accommodations must be reasonable compared to alternatives;
- Lodging will be reimbursed based on reasonable rates for the city in which treatment is provided, not to exceed \$300 per night;
- Lodging expenses are only reimbursable for the night prior to, and during the course of receiving, the specified services. Reimbursement of lodging expenses in excess of the maximum applicable rate set forth by the Internal Revenue Service and updated from time to time (e.g., \$50/night per person in 2025), shall be reported by the Health Plan as income to you, your spouse or your dependent child, as applicable; and
- Lodging expenses are not available if you, your spouse or your dependent child has traveled to their state of residence in order to receive the specified services.

CONDITIONS AND LIMITATIONS

- All expenses must be submitted in accordance with Plan rules and must be accompanied by a receipt to be eligible for reimbursement;
- No pre-authorization is required for the travel and lodging benefits at this time, but you may be required to attest that the specified services were not legally available in your current jurisdiction; and

- the following expenses are examples of items that are not reimbursable by the Health Plan:
 - ◊ meals;
 - ◊ travel and lodging expenses in connection with the termination of pregnancy that are not provided in a Hospital, clinical or similar medically appropriate setting;
 - ◊ travel and lodging expenses that are not primarily related to obtaining the specified services;
 - ◊ international travel or lodging expenses;
 - ◊ car rentals;
 - ◊ car or personal vehicle maintenance, repair or depreciation costs;
 - ◊ telephone, internet or other communication costs;
 - ◊ personal care items (e.g., toiletries);
 - ◊ expenses primarily for entertainment;
 - ◊ expenses for the cost of alcohol, tobacco, cannabis, vaping and other similar products; and
 - ◊ any expenses for anyone other than the individual traveling to receive the specified services and one medically appropriate companion, as applicable.

(r) 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 ventilator or respirator, up to the Allowable Charge for purchase.

An item that duplicates the function of equipment already covered by the Health Plan for the patient's use is not covered;

- artificial limbs, eyes and other prosthetic devices;
- casts, splints, binder or orthotic devices, crutches, braces, and orthotics;
- oxygen and the rental of equipment for giving oxygen;
- one wig for chemotherapy or radiation therapy-induced hair loss; and
- certain specialized medical supplies including ostomy supplies, compression burn garments and specialty dressings, when Medically Necessary.

Some diabetic supplies may be covered under the Health Plan's prescription drug benefit.

If you locate a Non-Network source that is offering a medical supply at a cost to the Health Plan that is less than what the Health Plan would have paid to a Network provider, please contact the Health Plan. If the Health Plan realizes a cost savings as the result of your efforts, you may be eligible for payment under the Health Plan's Recovery Incentive Program (refer to the *Recovery Incentive Program* section beginning on page 116 for more information).

(s) Mental Health & Substance Abuse

1. The Health Plan requires pre-authorization for the following mental health and substance abuse services:

- inpatient hospitalization for the treatment of substance abuse or mental health;
- partial hospitalization for the treatment of substance abuse or mental health;
- residential treatment for substance abuse or mental health; and
- intensive outpatient treatment for substance abuse or mental health.

Before beginning any of these treatments, your doctor should contact Anthem Blue Cross Utilization Management Review Department at **(800) 274-7767** for pre-authorization, regardless of whether or not they are a Network or Non-Network provider. International medical services are provided by Blue Cross Blue Shield Global Core. For pre-authorization, contact Blue Cross Blue Shield at **(800) 274-7767**.

2. Outpatient mental health and substance abuse services are covered when Medically Necessary.

(t) Nursing Care

There is an 860-hour annual limit on home nursing care. The services of a registered nurse, licensed practical nurse or licensed vocational nurse (not related to you or your dependents by blood or marriage) provided at home are covered when they are determined to be Medically Necessary.

The charges of private duty nurses in a Hospital are not covered. That is because a Hospital provides a staff of registered nurses for care during hospitalization, so those charges are included in the Hospital's room and board charges.

The final decision as to whether home nursing care will be covered by the Health Plan will be made by the Health Plan or the Board of Trustees and based solely on the doctor's orders, nursing notes and other evidence of the type of care provided.

Pre-authorization is not required for home nursing care. However, if your Physician has prescribed extensive home nursing care, you should contact the Health Plan office to ascertain whether case management, which is handled by Anthem Blue Cross, may be appropriate to assist you in determining if the proposed care will be considered Medically Necessary.

Custodial Care is not covered, except under Hospice care. See the *Hospice Care* section beginning on page 67 for more information.

(u) Off-Label Drug Use

Off-Label Drug Use will be considered Medically Necessary when all of the following conditions are met:

- the drug is approved by the United States Food and Drug Administration;
- 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
- 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 must also be determined by the Health Plan or the Board of Trustees to be "non-Investigational" for the purposes of benefit determination.

This policy shall not be construed to require coverage for any drug when the United States Food and Drug Administration has determined its use to be contraindicated.

Please refer to the definition of Medically Necessary in the Glossary of this Summary Plan Description on page 136.

(1) Pre-Authorization for Specialty Drugs through CVS Specialty

The Health Plan requires pre-authorization for specialty medications to help prevent Off-Label Drug Use. This means that a small subset of certain highly specialized medications must be authorized by CVS Specialty before they can be covered under the Health Plan benefits. If you submit a prescription for a specialty medication to be filled, CVS Specialty will automatically begin the drug approval process by contacting the prescribing Physician. The specialty drug approval process typically takes one to three days, depending on the prescribing Physician's response time.

(v) Palliative Care

The Health Plan provides Palliative Care benefits through Motion Picture Television Fund. To get started or to learn if Palliative Care is right for you, call **(818) 876-1739**.

(w) Physician Care

The Health Plan provides coverage for the following Physician care (in-Hospital or out-of-Hospital):

- home, office and Hospital visits; and
- services of Physicians, surgeons and assistant surgeons, including specialists.

The allowance for a Physician assistant surgeon will not exceed 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, except if determined otherwise by Network pricing.

The use of an assistant surgeon must be 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.

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.

(x) Preventive Care

Preventive care includes certain screenings, immunizations and other services for children, adolescents and adults that are generally intended to prevent illness, disease and other health issues. Common preventive care services include depression screening for adolescents, biennial breast cancer mammography for women aged 40 to 74 years, and colorectal cancer screenings from a Network provider every 10 years for adults ages 45 through 75.

(1) No Cost-Sharing for Network Preventive Care Services

The Health Plan covers certain preventive services at 100% with no Deductible or Co-Payment if they are rendered by a Network provider, so long as the services are Medically Necessary and you meet any age, risk or frequency requirements for the services. Preventive care services provided by a Non-Network provider will be paid at the applicable Non-Network Co-Insurance level.

Preventive care services covered at 100% with no Cost-Sharing include the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("Task Force") with respect to the individual involved. For a complete list of "A" and "B" recommendations of the Task Force see: www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("ACIP") with respect to the individual involved. For a complete list of vaccine recommendations and guidelines from the ACIP see: www.cdc.gov/acip-recs/hcp/vaccine-specific/index.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screenings not otherwise addressed by the recommendations of the Task Force, as recommended by the Women's Preventive Services Initiative ("WSPI"). For a complete list of Recommendations from the WSPI see: www.womenspreventivehealth.org/wellwomanchart/.
- PSA tests (prostate-specific antigen tests) for males between ages 40 and 69.

The Health Plan will cover preventive care services or supplies from a Non-Network provider with no Cost-Sharing ONLY if there is no qualified/available Network provider to provide the service or supply.

Please contact the Health Plan office for a full list of preventive care services that are currently covered at this level under the Health Plan or if you have questions concerning any age, risk or frequency limitations that apply. Note that the list of covered preventive care changes from time to time as preventive care services and supplies are added or taken off the government mandated list of required preventive care. The Plan follows federal law that determines when these changes take effect. Any additional recommendations provided by the Task Force in the future will be covered as of the first Plan Year that is one year after the service was added to the list.

Additional detail regarding these preventive care services may be found online at: www.healthcare.gov/coverage/preventive-care-benefits.

(2) Cost-Sharing When Preventive Health Services Are Provided as Part of an Office Visit

Generally speaking, the Cost-Sharing requirement for office visits during which recommended preventive healthcare services are rendered, either in whole or in part, depends upon how the preventive health service is billed and the primary nature of the office visit. Cost-Sharing for office visits will be applied if:

- a preventive care service is billed separately by your provider from the office visit where the primary purpose of the visit was for preventive care services; or
- the primary purpose of the office visit was not to provide a preventive care service or item, regardless of whether preventive care services are billed separately from an office visit.

Cost-Sharing for office visits will not be applied if recommended preventive care services are not billed separately from an office visit and the primary purpose of the visit was the delivery of a preventive care service or item.

Also, there may be times when you are seen by your doctor for your annual physical examination, but your doctor may order several tests. Some of those tests may be considered preventive care. These tests will be paid at 100% of the Network contract allowance only if in Network. Some of the tests ordered by your doctor might not be for preventive care services and may be subject to any applicable Deductibles, Co-Payments or Co-Insurance.

For example:

If you go to a Network provider for a sore throat and while there it is recommended that you have your cholesterol checked, the office visit is subject to the Deductible/Co-Payment/Co-Insurance, and the cholesterol test is paid at 100%. Additionally, if you are diagnosed with a condition such as hyperlipidemia (high cholesterol) and your doctor performs a cholesterol test, then that test is subject to Cost-Sharing as it is in connection with a medical condition and not preventive care services.

Please also note that the Health Plan will only pay for preventive care services which are considered Medically Necessary. For example, a routine colonoscopy for an individual under the age of 50 would be subject to a review of Medical Necessity.

The following are not covered under preventive care services:

- vitamins except as required by law;
- food supplements;
- concierge medical services or other personalized medical services billed as an all-

inclusive package, whether or not an itemized bill is submitted for a related routine physical examination;

- holistic treatment;
- personal trainers, health club membership or other fitness instruction;
- athletic wear; or
- athletic or exercise equipment.

(y) Telehealth

For the protection and safety of all Health Plan participants, the Health Plan's Board of Trustees has unanimously approved a Plan amendment that will temporarily provide coverage for both Network and Non-Network telemedicine and telepsychology services. That means that, until further notice, the Health Plan will cover office visits that can properly be conducted online with a licensed provider, as long as those visits and services would otherwise be covered under the terms of the Health Plan.

You may visit your Network or Non-Network provider online or use Anthem's LiveHealth Online Network providers, subject to the Health Plan's applicable Deductibles and Co-Insurance rules. For further information, regarding Anthem's telemedicine and telepsychology programs, please visit www.livehealthonline.com, call **(888) LiveHealth (548-3432)** or email help@livehealthonline.com.

All other Health Plan rules remain in effect, including but not limited to the exclusion of services that are not Medically Necessary, the exclusion of marriage, family or relationship counseling and/or therapy, and the exclusion for charges in excess of the Allowable Charge limit (meaning you will be responsible for any Non-Network charges above the Allowable Charge).

Because this change is temporary, you will be notified when this special telemedicine benefit ends.

(z) Therapy

Therapy benefits (in-Hospital or out-of-Hospital) are only covered when prescribed by a Physician. A copy of the Physician's prescription for therapy is required by the Health Plan.

Therapy must be performed by a licensed, certified Physician or general practitioner within the scope of his or her license and is covered up to a maximum Allowable Charge of \$85 per visit. This limit is also applied to Network providers, including therapy performed in a Hospital setting on an outpatient basis.

For example:

If you receive Physical Therapy services from a Network provider and the Network charge is \$400, you will be responsible for 10% of the initial \$85 and 100% of the \$315 that is in excess of the \$85 limit. This example assumes that you have already met your annual Deductible.

The Health Plan will allow one office visit for the evaluation and management of a new patient. This initial visit is not subject to the \$85 allowable limit. Payment will be based on Network rates or Reasonable and Customary Allowed Amounts.

Multiple therapy treatments in one day by the same rendering provider are treated as one visit and are subject to the per visit maximum of \$85.

Whether a therapy treatment is covered is determined by the terms of the Health Plan. If you have any questions about the coverage of the Health Plan, you may contact the Health Plan office.

Therapy includes:

1. Physical Therapy (PT) administered by an M.D., D.O. or registered physical therapist;
2. speech therapy (ST) and Occupational Therapy (OT) are not covered when they are part of

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;

3. Biofeedback for covered non-psychiatric diagnoses;
4. vision therapy (orthoptic training), excluding refractions, is covered when prescribed by a Physician for the treatment of strabismus and other disorders of binocular eye movements or of strabismic amblyopia;
5. osteopathic adjustments or manipulations by a doctor of osteopathy; and
6. continuously monitored cardiac rehabilitation (a phase II program).

(a-1) X-Rays

The Health Plan covers Medically Necessary diagnostic X-ray and testing services (in-Hospital or out-of-Hospital) such as MRI and CAT scan.

Section 10. What's Not Covered Under Medical Benefits

No benefits are payable for:

1. Any treatment, service or claim that is not Medically Necessary (see the definition of Medically Necessary on page 136).
2. Charges in excess of Allowable Charges or the applicable percentage payable of the Reasonable and Customary Allowed Amounts.
3. Expenses incurred that are not due to Sickness or bodily injury (other than covered preventive care services).
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 healthcare provider who is related by blood or marriage to you or your dependents, or living with the person requiring treatment.
8. Treatment or procedures that are Experimental or Investigative.
9. Complementary and Alternative Medicine, including but not limited to homeopathic, naturopathic and holistic medicine, except as the Health Plan provides benefits for Acupuncture and Chiropractic Care.
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 Facility or has certification from a private accreditation agency accepted by the state in lieu of state licensure.
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 and MRI/CAT scans related to dental care. Some dental care is covered under the Health Plan's dental benefit. Refer to the section titled *Dental Benefits* beginning on page 91 for more information.
16. Glasses, contact lenses or eye refractions except when provided following a covered eye surgery, such as for cataracts. Some vision care is covered under the Health Plan's vision

benefit. Refer to the section titled *Vision Benefits* beginning on page 97 for more information.

17. Any surgical procedure, such as LASIK, to correct a refractive error.
18. Outpatient prescription drugs, except as specifically covered under the Health Plan's prescription drug benefit. See the *Prescription Drug Benefits* section beginning on page 83 for information about covered drugs.
19. Services and supplies for which the patient legally is not required to pay.
20. Expenses written off by the provider or not charged to the patient.
21. Extra or increased charges, in addition to basic service, for services provided after hours, during late hours at a 24-hour facility, on weekends and holidays, or on an emergency basis.
22. Charges for completing claim forms, reports, etc.
23. Charges for copying medical file records.
24. Charges associated with the translation of foreign claims.
25. Charges for mailing and shipping of medical supplies.
26. Sales or other taxes on services, products and equipment.
27. Services or testing rendered via telephone, video, electronic streaming, internet consultations or any other electronic medium. See *Telehealth* on page 76 for more information.
28. Charges for Sickness or injury occurring from the commission of an illegal act.
29. Rest cures or Custodial Care (except as specifically provided under the Hospice benefit).
30. Infertility treatment that is not received or provided through Carrot or that is in excess of the limits specified.
31. Reversal of vasectomies or tubal ligation.
32. Autologous blood storage charges, unless in association with a scheduled surgery that is normally covered by the Health Plan.
33. Umbilical cord blood collection and storage charges.
34. Cosmetic Surgery and prescription drugs prescribed for cosmetic purposes (including collagen injections and laser resurfacing), except when reconstructive surgery is performed to correct a deformity resulting from previous surgery, Accidental injury, congenital deformity, or to provide Medically Necessary transgender related treatment to the extent required under Section 1557 of the Affordable Care Act.
35. Routine foot care, including orthopedic shoes, heel lifts and shoe inserts except when special shoes/inserts are necessary to prevent complications of diabetes.
36. Cutting, trimming or partial removal of toenails, corns and calluses, except when Medically Necessary due to vascular impairment or loss of protective sensation caused by diabetes or other disease.
37. Obstetrical care including delivery for your dependent child, except for Complications of Pregnancy, ACA preventive care services with a Network provider or termination of a pregnancy as outlined in *What's Covered Under Medical Benefits*, subsection: (q) *Maternity Care*, beginning on page 70.

38. Prepared child birth classes (including Lamaze), parenting classes and doulas.

39. Fees for a masseur, masseuse, massage therapist (M.T.), dance therapist or art therapist.

40. Academic evaluations, psychological or neuropsychological testing of school age children that is psycho-educational and not Medically Necessary.

41. Educational therapy, play therapy, etc. for the treatment of learning disabilities.

42. Fees for health club or gymnasium memberships, which includes personal trainers, Pilates, yoga or other fitness instruction.

43. Marriage, family or relationship counseling, and/or therapy.

44. Transportation, except local ambulance service or as provided in the *Ambulance Service* section beginning on page 63.

45. General use and/or convenience items, including, but not limited to: hydrocollators, whirlpool baths, sunlamps, heating pads, exercise devices and similar 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, stair lifts 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.

52. Bariatric surgery, unless it meets the Health Plan's requirements for bariatric surgery (available in writing from the Health Plan office).

53. Unlicensed assistive personnel and/or providers whose services are custodial in nature, including but not limited to home health aides.

54. Patient or provider travel costs or expenses.

55. Supplies incidental to outpatient tests or procedures, including sterile trays, needles, gloves, cannulas, catheters, alcohol wipes, electrodes, lead wires, tubing, tape, dressings, gauze, bandages, saline, and routine casting and strapping supplies.

56. Services incidental to outpatient tests, procedures or examinations, including venipuncture, specimen handling and conveyance, unless allowed by Network pricing.

57. Neuromuscular stimulator or similar equipment except when appropriate to prevent or treat muscular atrophy due to neuromuscular disease or injury (not covered to prevent or treat disuse atrophy due to pain, including post-operative pain).

58. Hypnotherapy, regardless of diagnosis.

59. Medical expenses incurred by an organ donor for you or your dependents to the extent that such expenses are eligible for coverage under the donor's own group health insurance.

60. Cold or heat therapy equipment for home use.

61. Concierge medical services or other personalized medicine services billed as an all-inclusive package.

62. Charges billed for procedure codes determined by the Health Plan to be incidental or mutually exclusive to or unbundled from a more global procedure code, except as determined by Network pricing.
63. Oncotype DX Cancer Assay diagnostic laboratory test, unless it meets the Health Plan's requirements for coverage, including Medical Necessity. Please contact the Health Plan office for detailed coverage requirements.
64. Outpatient vitamins except for B12 injections when Medically Necessary for pernicious anemia or other B12 deficiency.
65. Food supplements and over-the-counter drugs that are not required to be covered under the Affordable Care Act.
66. Lost or stolen Durable Medical Equipment, medical supplies, orthotics, hearing aids and/or medications.
67. Certain specialty drugs are not covered under the medical benefit and must be obtained through CVS Specialty.
68. Fees for weight loss programs (*i.e.*, Weight Watchers, Nutrisystem, etc.).
69. Treatment or services not within the provider's scope of license.

Section 11. Medical Necessity of Ongoing Treatment for Outpatient Mental Health, Substance Abuse and Physical Therapy Services

The Health Plan covers visits for outpatient mental health, substance abuse and Physical Therapy services, as long as the services are determined to be Medically Necessary under the terms of the Plan. The Health Plan does not require pre-authorization for outpatient mental health, substance abuse or

Physical Therapy services, but it does require that all participants and dependents demonstrate that on-going treatment beyond 30 visits is Medically Necessary.

After 20 visits during a single course of treatment, the Health Plan will notify participants and dependents to remind them they will need to provide the Health Plan with sufficient evidence to confirm Medical Necessity after the 30th visit. The Health Plan will send a second notification to participants and dependents after the 30th visit and will not approve any additional claims beyond the 30th visit until the Health Plan is provided with the required information to confirm Medical Necessity of ongoing treatment.

Please refer to page 136 for the definition of Medically Necessary.

You can work with your provider to gather the information required to confirm Medical Necessity, including the following for mental health and substance abuse:

- What is the diagnosis or condition?
- When did the condition begin?
- When did the treatment begin?
- What is the frequency of sessions?
- What is the length of sessions?
- What is the treatment-approach for the patient? If it is evidence-based treatment, give details to document evidence-based treatment.
- Has medication or treatment been prescribed or considered? If so, what is the frequency and duration of the prescribed treatment? If none has been prescribed, why not?
- What symptoms were being addressed at the start of therapy?

- What has the patient's progress been during the course of therapy?
- What symptoms are currently being addressed in therapy?
- Is the patient continuing to make progress?
- What are the barriers to progress, and how are they being addressed?

The following information is required for Physical Therapy:

- An initial medical history and a Physician exam conducted by the referring provider (independent of a physical therapist) to determine factors or medical conditions contributing to the symptoms and/or functional impairments.
- Details regarding any measurable improvement and the progress towards identified goals.
- The short-term and long-term functional treatment objectives that are specific, quantitative and objective.
- The treatment techniques and interventions to be used, including frequency, and duration required to achieve goals.

- A summary of all treatment provided, and documentation of results achieved (response to treatment, changes in the patient's condition, problems encountered, and goals met) during previous therapy services, as applicable.
- What are the specifics of the patient's condition that preclude transition to a home exercise program?

You must provide the Health Plan with sufficient information and details to enable a medical professional to evaluate and confirm whether the type, quality, frequency and duration of treatment are consistent with the Plan's definition of Medically Necessary. If you prefer not to provide the Health Plan with written materials or records, you may request in writing that the Health Plan conduct a peer-to-peer phone conversation between your provider and the Health Plan's independent medical reviewer as part of the Health Plan's review for Medical Necessity.

Notwithstanding the foregoing, nothing shall prohibit the Health Plan from requesting you to confirm Medical Necessity for a service or course of treatment prior to the 31st visit, including courses of unusual or irregular duration, frequency, or scope of services provided over a period of time.

ARTICLE V. PRESCRIPTION DRUG BENEFITS

For additional information about prescription drug benefits available, visit www.dgaplans.org/prescription-benefits-overview.

The Health Plan covers drugs and medicines that require the written prescription of a Physician. Over-the-counter drugs and medicines are not covered by the Health Plan except as required by the Affordable Care Act.

Below (↓) is a schedule summarizing the prescription drug benefits under the Health Plan:

	Retail Pharmacy	CVS Caremark Maintenance Choice
Delivery/Pickup location	Any retail pharmacy in the CVS Caremark Network	Any local CVS Caremark, Longs Drugs or Navarro pharmacy or via CVS Caremark Mail Service Pharmacy
Deductible	There is no Deductible associated with the prescription drug benefit.	
Allowable Quantity	Up to 30-day supply	Up to 90-day supply
Generic Drugs Co-Payment	\$10	\$25
Brand Name Drug Co-Payment	\$24	\$60
Lifestyle Drug Co-Payment (<i>i.e.</i> , erectile dysfunction drugs, proton pump inhibitors, weight loss drugs and sleep aids)	Greater of \$40 or 50% of the cost of the medication	Greater of \$60 or 50% of the cost of the medication

You have three options when filling prescriptions:

- through a retail pharmacy (for up to 30-day supplies);
- through a local CVS pharmacy or CVS Caremark Mail Service Pharmacy (for up to 90-day supplies); or
- through CVS Specialty for specialty drugs.

In the case of long-term maintenance medication, you are required to fill your prescriptions through a local CVS Caremark pharmacy or CVS Caremark Mail Service Pharmacy (Maintenance Choice). Questions regarding prescription drug coverage should be directed to CVS Caremark Customer Care at:

CVS Caremark Customer Care
(855) 271-6601 or the customer service number on your prescription ID card
www.caremark.com

Section 1. CVS Caremark Maintenance Choice for Long-Term Maintenance Medications

Prescriptions for medications that are taken on a long-term basis (three months or more) must be obtained through a local CVS Caremark pharmacy or CVS Caremark Mail Service Pharmacy (Maintenance Choice). The first two times that a long-term drug is purchased in 30-day supplies at a retail pharmacy other than a local CVS Caremark pharmacy, you will pay the applicable retail Co-Payment. Subsequent prescriptions, however, must be filled with a local CVS Caremark pharmacy or through CVS Caremark Mail Service Pharmacy to avoid paying the entire cost of the medication. See below for more information.

(a) CVS Caremark Mail Service for Maintenance Medications

Prescriptions for medications that are taken on a long-term basis (three months or more) must be obtained through a local CVS Caremark pharmacy or CVS Caremark Mail Service Pharmacy (Maintenance Choice) to limit your out-of-pocket costs as much as possible. You may obtain 90-day prescriptions through any of CVS Caremark's retail locations throughout the United States or CVS Caremark Mail Service Pharmacy by paying the applicable mail order Co-Payment.

After two 30-day fills of your maintenance medications at any retail pharmacy, you must pay the entire cost of the maintenance prescription if you continue to fill them at a retail pharmacy other than a local CVS Caremark pharmacy or through CVS Caremark Mail Service Pharmacy. When obtaining a prescription through CVS Caremark Mail Service Pharmacy, you may purchase up to a 90-day supply at a time.

You can log on to your account with CVS Caremark at www.caremark.com to find out which of your medications is impacted by the Health Plan's rules for long-term maintenance medications. You should continue to obtain all short-term medication, such as antibiotics, at a retail pharmacy.

Mail order refills may be obtained by calling CVS Caremark at the number below or mailing the refill form sent with your medication. In addition, you can manage your mail order refills on the website noted above. For additional information about CVS Caremark or its mail order program or to order a refill, please call **(855) 271-6601** or visit www.caremark.com.

CVS Caremark does not deliver outside of the United States. If you are leaving the country for extended periods of time, you may contact the Health Plan office to make arrangements to obtain a vacation override on your prescriptions. You may also submit claims for covered medications that are obtained at foreign pharmacies to CVS Caremark. For more information on submitting claims to CVS Caremark, refer to the *Filing a Claim* section beginning on page 101.

Certain types of covered long-term medications (e.g., compounds) cannot be delivered by CVS Caremark Mail Service Pharmacy. When a long-term medication is not available through CVS Caremark Mail Service Pharmacy, you may obtain the medication at a local CVS Caremark pharmacy at the applicable retail Co-Payment.

For existing prescriptions, CVS Caremark requires at least 75% of a prescription filled by CVS Caremark Mail Service Pharmacy be used before a new prescription for the same medication can be filled at a local CVS Caremark pharmacy or CVS Caremark Mail Service Pharmacy (Maintenance Choice). For additional information about the Maintenance Choice program, please call **(855) 271-6601** or visit www.caremark.com.

(b) CVS Caremark Maintenance Choice Program Co-Payments

For a prescription obtained through CVS Caremark's Maintenance Choice program, the following Co-Payments apply:

Generic Drugs	Brand Name Drugs	Lifestyle Drugs
\$25*	\$60	You pay the greater of \$60 or 50% of the cost of the drug.

**Generic FDA-approved contraceptives for females are covered at 100% with no Cost-Sharing from Network providers. There is no additional charge for brand if a generic is unavailable or generic is medically inadvisable.*

See the section titled *Additional Prescription Drug Rules* beginning on page 86 for more information on Health Plan policies that could affect the amount you pay for prescription medication. If you obtain less than a 90-day supply of a medication through CVS Caremark Mail Service Pharmacy, the same Co-Payments will still be applied (*i.e.*, \$25 for generic drugs, \$60 for brand name drugs and the greater of 50% or \$60 for lifestyle drugs). When the prescribed amount of a medication is restricted by law, the Health Plan will prorate the CVS Caremark Maintenance Choice Co-Payment based on the amount of the restricted medication that is prescribed.

The CVS Caremark Maintenance Choice Co-Payments are higher than the retail Co-Payments listed in this Summary Plan Description. However, because you can obtain up to a 90-day supply of a medication through CVS Caremark's Maintenance Choice, while prescriptions obtained through retail pharmacies are limited to a 30-day supply, Maintenance Choice Co-Payments are nearly 17% lower on a per-drug basis.

Section 2. Retail Pharmacies

CVS Caremark provides nationwide access to more than 68,000 retail pharmacies in their Network. To find a CVS Caremark pharmacy, you can call **(855) 271-6601**. In addition, you may access an up-to-date list of CVS Caremark pharmacies at www.caremark.com.

When obtaining a prescription through a retail pharmacy other than a local CVS Caremark pharmacy, you may purchase up to a 30-day supply at a time. If you need a larger supply, you should obtain your medication through a local CVS Caremark pharmacy or CVS Caremark Mail Service Pharmacy (Maintenance Choice). To use a local CVS Caremark pharmacy, follow these simple procedures:

- present your CVS Caremark ID card to a CVS Caremark pharmacist; and
- pay the applicable Co-Payment amount.

Prescriptions purchased without your ID card or at any Non-Network pharmacy may cost more. Refer to the section titled *Non-Network Pharmacies* beginning on page 86 for more information. Please do not send receipts to the Health Plan office for reimbursement. There are no claim forms to complete or receipts to mail to the Health Plan office.

(a) Retail Co-Payments

For a prescription obtained at a Network pharmacy (up to a 30-day supply), the following Co-Payments apply:

Generic Drugs	Brand Name Drugs	Lifestyle Drugs	ACA Preventive Care Drugs
\$10	\$24	You pay the greater of \$40 or 50% of the cost of the drug.	None

See the section titled *Additional Prescription Drug Rules* on this page for more information on Health Plan policies that could affect the amount you pay for prescription medication.

Section 3. Non-Network Pharmacies

You may purchase your prescription drugs at a Non-Network pharmacy. If you purchase prescription medication at a Non-Network pharmacy:

- you will not receive the Network discount;
- you will have to pay the full amount at the time of purchase; and
- you will have to file a claim form for a partial reimbursement.

To file a claim, you can obtain a Prescription Reimbursement Claim Form on www.dgaplans.org/forms and submit the necessary information and receipts to the address below:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

CVS Caremark will reimburse you for the amount they would have covered at the discounted rate, less the applicable Co-Payment amount.

Section 4. Additional Prescription Drug Rules

(a) Brand vs. Generic: You Pay the Difference

When you choose to take a brand name drug when a generic equivalent is available, you will pay the cost difference between the brand name drug and the generic drug, plus the generic Co-Payment. The increased Co-Payment applies when there is a generic equivalent available, even if your doctor has indicated "dispense as written" for a brand

name drug. This applies only to generic equivalents, where the drug is the exact same drug certified by the United States Food and Drug Administration. By law, generic drugs must contain the same active ingredients and be equivalent in strength and dosage form to the brand name product. The difference between the price of the brand and generic drugs does not count towards your calendar year All-Inclusive Network Out-of-Pocket Limit.

(b) Lifestyle Drugs

Lifestyle drugs are commonly used to improve the quality of one's life and treat non-life threatening and non-painful conditions. Erectile dysfunction drugs, proton pump inhibitors, weight loss medications and sleep aids are examples of covered lifestyle drugs. The Health Plan has special rules for the coverage of erectile dysfunction drugs, proton pump inhibitors, weight loss medications and sleep aids.

These medications fall into one of three categories:

- Preferred drugs
- Non-preferred drugs
- Restricted drugs

(1) Preferred Drugs

Preferred drugs are covered under the Health Plan based on standard rules. CVS Caremark periodically reviews its list of covered medications, called the Advanced Control Formulary, and may exclude medications when clinically equivalent alternatives are available and offer significant cost savings to you. Changes to the formulary affect certain medications that are covered under the Health Plan and how much you pay out-of-pocket for them.

(2) Non-Preferred Drugs

Non-preferred drugs are subject to step therapy. This requires you to try a preferred drug before electing a non-preferred drug.

(3) Restricted Drugs

Restricted drugs are not covered under the prescription drug program without a coverage review. To obtain a coverage review, contact CVS Caremark at **(855) 271-6601**.

(c) Specialty Drugs

Specialty medications are drugs that are used to treat complex conditions and illnesses such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. These drugs usually require special handling, special administration or intensive patient monitoring. Medications used to treat diabetes are not considered specialty medications. Whether they are administered by a healthcare professional, self-injected or taken by mouth, specialty medications require an enhanced level of service.

Your prescription drug program requires that certain specialty medications be accessed through CVS Specialty. These specialty medications are not covered through your medical benefit. The list of medications subject to the program is available by calling the number on your prescription drug ID card. If you are currently using specialty medications affected by the program and you do not obtain them through CVS Specialty, you will be required to transfer those prescriptions to CVS Specialty. If you continue to purchase your medications from your doctor or another pharmacy, you may be responsible for their full cost, in addition to your Co-Payment. When you order a covered specialty medication through CVS Specialty, your out-of-pocket cost will be limited to the applicable Maintenance Choice Co-Payment.

If you have an extenuating medical condition that prevents you from transitioning your specialty medication to the pharmacy benefit, you may be granted an override and continue obtaining your specialty medication using your medical benefit as long as there is a reviewed medical reason not to transition.

PRUDENTRX SOLUTION FOR SPECIALTY MEDICATIONS

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the Health Plan has contracted to offer participants the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists patients by helping them enroll in manufacturer Co-Payment assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% Co-Insurance, after satisfaction of any applicable Deductible. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer Co-Payment assistance program for their specialty medication, the patient will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Co-Payment assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining Co-Payment assistance from drug manufacturers when available to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses.

Participation in the program requires certain data to be shared with the administrators of these Co-Payment assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at **(800) 578-4403** to register for any manufacturer Co-Payment assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the Co-Payment assistance that they

provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call **(800) 578-4403**. Eligible participants who fail to enroll in an available manufacturer Co-Payment assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% Co-Insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at **(800) 578-4403** to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's Co-Payment assistance program, for medications covered under the PrudentRx Solution will not count toward your plan Deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act, will not count toward your Deductible or out-of-pocket maximum (if any), unless otherwise required by law.

A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is Medically Necessary for a particular individual.

PrudentRx can be reached at **(800) 578-4403** to address any questions regarding the PrudentRx Solution.

(d) Off-Label Drug Use

Off-Label Drug Use will be considered Medically Necessary when all of the following conditions are met:

- the drug is approved by the United States Food and Drug Administration;
- 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
- 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 must also be determined by the Health Plan or the Board of Trustees to be "non-Investigational" for the purposes of benefit determination. This policy shall not be construed to require coverage for any drug when the United States Food and Drug Administration has determined its use to be contraindicated. Please refer to the definition of Medically Necessary in the *Glossary* of this Summary Plan Description on page 136.

(e) Preventive Care Prescription Drugs

Some drugs are covered at 100%, as they meet the definition of a preventive benefit under the Health Plan. Refer to the *Preventive Care* section beginning on page 74 for more information.

If you are unsure whether or not a particular drug is covered under the Prescription Drug Benefit, please contact the Health Plan office.

(f) Diabetic Supplies

The following diabetic supplies are covered under the Health Plan's prescription drug benefit:

- lancets;
- diabetic testing reagents (test strips);
- single-use insulin syringes (reusable syringes are not covered);
- alcohol wipes or swabs; and
- glucometers.

Some glucometers and replacement supplies for certain insulin pumps are not covered. Please contact CVS Caremark at **(855) 271-6601** for further information.

(g) Pre-Authorization of Benefits

Certain medications may require pre-authorization. Drugs requiring pre-authorization must first be approved by CVS Caremark in order to be covered under the prescription benefit. If pre-authorization is required, CVS Caremark will notify the provider. A medication may require pre-authorization for several reasons, including availability of a generic drug, limited effectiveness, increased risks of off-label use or higher-than-average cost. Prior to filling a prescription at a CVS Caremark Network pharmacy, you can obtain a pre-authorization by calling CVS Caremark at **(855) 271-6601**. For information on how to appeal pre-authorizations denied by CVS Caremark, refer to the section titled *Claims and Appeals Procedures, (a) Claims in General* beginning on page 106 for more information.

(h) Step Therapy

Step therapy is similar to pre-authorization in that affected drugs require prior approval in order to qualify for Health Plan coverage. In order for affected drugs to be covered, you must first try an established, cost-effective alternate medication,

called a first-line therapy, as defined under the step therapy program for the condition being treated. These first-line therapies are usually generics proven to be safe, effective and affordable, providing the same health benefit as more expensive prescription drugs, but at a lower cost. Only after the first-line therapy has been tried without success will the Health Plan cover a second-line therapy.

Step therapy programs are decided upon by independent, licensed doctors, pharmacists and other medical experts who review the most current research on drugs approved by the Food and Drug Administration for safety and effectiveness.

(i) Advanced Control Formulary

CVS Caremark periodically reviews its list of covered medications, which is referred to as the Advanced Control Formulary, and may exclude medications when clinically equivalent alternatives are available and offer significant cost savings to you. Changes to the formulary affect which medications are covered under the Health Plan and how much you pay out-of-pocket for certain prescriptions.

If you are taking a maintenance medication, be sure to review the new list in case the status of your medication has changed. If a medication you currently take appears on the list of excluded medications, you should discuss with your doctor about a preferred alternative. The Advanced Control Formulary will continue to offer access to safe and effective medications as alternatives to these drugs.

Section 5. Coordination of Prescription Drug Benefits

The Health Plan's prescription drug benefits have the same coordination of benefits rules as medical benefits. For an explanation of the Health Plan's coordination of benefits rules, refer to the *Coordination of Benefits* section beginning on page 54.

Section 6. What's Not Covered Under Prescription Drug Benefits

1. Over-the-counter drugs not required to be covered under the Affordable Care Act
2. Vitamins, even if prescribed or recommended by a Physician
3. Prescription drugs not approved by the Food and Drug Administration for the treatment rendered
4. Prescription drugs related to non-covered procedures
5. Erectile dysfunction drugs in excess of 10 pills each 30 days
6. Intranasal corticosteroid prescription drugs, unless the patient has been refractory to over-the-counter intranasal corticosteroid drugs
7. Medical foods (*i.e.*, vitamin combinations, probiotics, nutritional supplements)
8. Non-sedating antihistamines

ARTICLE VI. DENTAL BENEFITS

For additional information about the dental benefits available under the Health Plan, visit www.dgaplans.org/dental-benefits-overview.

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

You can reach Delta Dental at:

Delta Dental of California
P.O. Box 997330
Sacramento, California 95899-7330
(888) 335-8227
www.deltadentalins.com

As of January 1, 2025, the dental maintenance organization ("DMO") option is no longer available to California residents.

Section 1. Network Dentists

The Health Plan's dental Network is the Delta Dental PPO.

Not all Delta Dental dentists participate in the Delta Dental PPO. To receive the Health Plan's Network dental benefits, you must visit a Delta Dental PPO dentist ("Network dentist").

When you use a Network dentist, you will receive higher benefits than you would receive when going to a Non-Network dentist.

There are several ways that you save money with Network dentists:

- there is no Deductible when using a Network dentist;
- all procedures, except orthodontia, are paid at a higher percentage; and

- Network dentists have agreed to charge discounted fees.

You will see the greatest savings when you visit a Delta Dental PPO dentist. Not only is there no Deductible, but with the discounted fees and the Health Plan paying a higher percentage of Network charges, you pay a smaller percentage of a smaller amount.

Delta Dental PPO dentists will take care of all paperwork and have agreed to charge only the patient share at the time of treatment.

FINDING A NETWORK DENTIST

There are several ways to locate a Network dentist:

- you can ask your dentist directly. Be sure to ask if your dentist participates in the Delta Dental PPO. Some Delta Dental dentists do not participate in the Delta Dental PPO;
- you can visit www.deltadentalins.com; or
- you can call Delta Dental at **(800) 427-3237**.

(a) Annual Maximum Benefit

The maximum payable benefit for covered dental expenses during a calendar year is \$2,500 per individual (including Network and Non-Network expenses). This limit does not apply to children under age 19.

(b) Network Deductible

There is no Deductible when using a Network dentist.

(c) Network Co-Insurance

For Network dentists, the Health Plan pays a percentage of charges based upon one of four categories of service:

Category of Service*	Co-Insurance
Category I	100%
Category II	80%
Category III	70%
Orthodontia	50%; Coverage only available for dependent children under age 19; Lifetime maximum payment of \$1,500 per dependent child.

**For a description of services offered under each category, see Section 5, What's Covered Under Dental Benefits on the next page (→).*

Section 2. Non-Network Dentists

You are not limited to Network dentists. Non-Network dentists include many dentists who participate with Delta Dental, but who do not participate in the Delta Dental PPO. Some dentists do not participate with Delta Dental at all.

If you go to a dentist who participates with Delta Dental but is not a Delta Dental PPO 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 in this section).

If you decide to go to a dentist who doesn't participate with Delta Dental, you will be responsible for any difference between the Reasonable and Customary Allowed Amounts and the amount that your dentist charges. Also, you may need to submit a claim form to receive this reimbursement.

For information on filing a dental claim, refer to the *Filing a Claim* section beginning on page 101.

(a) Annual Maximum Benefit

The maximum payable benefit for covered dental expenses during a calendar year is \$2,500 per individual (including Network and Non-Network expenses). This limit does not apply to children under age 19.

(b) Non-Network Deductible

Non-Network dental benefits are payable once you satisfy the calendar year Deductible. The Health Plan's dental benefit Deductible is separate from the medical benefits Deductible. There is no Deductible for Network dental benefits.

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 individuals have met the combined Deductible amount of \$100 in one calendar year, no further Deductibles will be charged to the family for that year.

(c) Non-Network Co-Insurance

Once you satisfy the Deductible, the Health Plan pays a percentage of Reasonable and Customary Allowed Amounts based upon one of four categories of service:

Category of Service	Co-Insurance
Category I	85%
Category II	60%
Category III	50%
Orthodontia	50%; Coverage only available for dependent children under age 19; Lifetime maximum payment of \$1,500 per dependent child.

You are responsible for the remaining percentage of charges and any amounts above Reasonable and Customary Allowed Amounts.

Section 3. Pre-Authorization of Benefits

Pre-authorization 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 pre-authorization for dental treatment. If you go ahead with treatment without having the treatment pre-authorized, the Health Plan will pay benefits only for the charges that would have qualified in a pre-authorization review. Therefore, you will be responsible for the difference in cost.

Call Delta Dental at **(800) 846-7418** for details on how to obtain pre-authorization.

Section 4. Dental Coverage Extensions

If you lose your coverage under the Health Plan, your dental benefits will be 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.

Section 5. What's Covered Under Dental Benefits

The expenses listed in this section are covered dental 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.

Refer to the section titled *Filing a Claim* beginning on page 101 for instructions of how to file a dental claim.

(a) Category I Expenses

The following Category I dental expenses are paid at 100% Network and 85% Non-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 14
- Space maintainers but only for covered individuals under 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 14

- Charges for emergency relief of dental pain on a day for which no other dental service, other than X-rays, is performed

(b) Category II Expenses

The following Category II dental expenses are paid at 80% Network and 60% Non-Network:

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

- 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 bridgework, 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 medical benefits.

(c) Category III Expenses

The following Category III dental expenses are paid at 70% Network and 50% Non-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 recement 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

(d) Orthodontic Treatments

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

Benefits are paid at 50% of Delta Dental's Reasonable and Customary Allowed Amounts and are paid on a prorated basis throughout the course of treatment. Covered Expenses are not subject to the dental Deductible.

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

(e) Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacement or additions to existing dentures or bridgework 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.

Section 6. What's Not Covered Under Dental Benefits

No dental benefits are payable for:

1. dental services or supplies that are not Medically Necessary;
2. any expenses covered under medical benefits;
3. services received from your or your dependents' relative either by blood or marriage;
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 Summary Plan Description;
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. prescription drugs;
19. anesthesia, except for general anesthesia for oral surgery; and
20. charges for Sickness or injury occurring from the commission of an illegal act.

ARTICLE VII. VISION BENEFITS

For additional information about vision benefits available, visit www.dgaplans.org/vision-benefits-overview.

Vision benefits are provided through VSP Vision (VSP) and are designed to provide benefits for regular eye examinations and vision care, including glasses and contact lenses.

You have the option of receiving vision care services either through a VSP-participating doctor or another eye care provider of your choice. VSP has an extensive nationwide Network of doctors who provide quality eye care and materials. If you use a non-VSP participating doctor, you will not be able to take advantage of VSP's negotiated rates and discounts.

Section 1. Co-Payments and Allowances

The Co-Payments and allowances that apply to the Health Plan's vision benefit are listed below.

	Service Frequency	Network Benefit	Non-Network Maximum Benefit*
Exams	Once per calendar year	\$30 Co-Payment	\$45 Co-Payment
Frames	Once every other calendar year	\$220 allowance \$240 allowance for featured frame brands	\$70 allowance
Lenses	Once per calendar year	\$200 allowance	Single vision lenses \$30 lined Bifocal lenses \$50 lined Trifocal lenses \$65 lined Contact lenses \$105 per lens per eye (elective) \$210 per lens per eye (Medically Necessary)

*after deducting applicable Network Co-Payment amount

Section 2. Your Other Expenses

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 in the *Contact Lenses* section beginning on page 100)
- A frame that costs more than the Health Plan's vision benefit 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
- Certain limitations on low vision care

Section 3. Network Doctors

To access your vision care benefits, simply contact a VSP doctor and make an appointment.

You can locate a VSP doctor by calling VSP at **(800) 877-7195** or going to www.vsp.com.

When making an appointment, identify yourself as a VSP patient. Indicate that you are covered under the Health Plan and provide your Plan ID number. The VSP doctor will then obtain the necessary authorization and information about your eligibility and coverage.

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.

Selecting a participating doctor from VSP's Network assures direct payment to the doctor.

Section 4. Non-Network Doctors

Services obtained from a non-VSP provider are in lieu of services from a VSP provider (*i.e.*, the Health Plan will not cover services from a non-VSP provider and a VSP provider in the same calendar year).

When you use a non-VSP doctor or provider, you are responsible for paying the provider for the full cost of services and then submitting a claim for reimbursement to VSP.

You must submit a claim within six months after services are provided. Otherwise, the claim will not be covered.

You will be reimbursed for covered services according to the VSP schedule of payments (detailed later in this section), which may or may not cover the costs of a non-VSP provider.

When a non-VSP participating provider is used, the Co-Payments listed in the section titled *Co-Payments and Allowances* on page 97 are also taken into account for reimbursement purposes.

Follow these steps when you use a non-VSP participating provider:

- 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.
- Send a copy of the itemized bill(s) to VSP at:

VSP Vision
Attn: Claims Services
P.O. Box 495918
Cincinnati, OH 45249-5918

The following information must be included in your documentation:

- your name and mailing address;
- your Plans ID number; and
- patient's name, date of birth and the relationship to you.

You may submit your vision care claim on a CMS-1500 form (available at www.dgaplans.org/forms) or any generic insurance claim form that may be available from your non-participating provider.

VSP will reimburse you in accordance with the following schedule. 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.

(a) Schedule For Non-Network Doctor Charges

The chart below (↓) lists the reimbursement allowances for non-VSP providers per calendar year. All amounts are after the deduction of the Co-Payments listed in the section titled *Co-Payments and Allowances* beginning on page 97.

Reimbursement Allowances for Non-Network VSP Providers	
Service	Reimbursement Allowance
Exams	Up to \$45
Frames	Up to \$70
Single Vision Lenses	Up to \$30 lined
Lined Bifocal Lenses	Up to \$50
Lined Trifocal Lenses	Up to \$65
Elective Contact Lenses	Up to \$105 per lens per eye
Medically Necessary Contact Lenses	Up to \$210 per lens per eye

The availability of services under the reimbursement schedule above is subject to the same time limits as those described in the section titled *What's Covered Under Vision Benefits* that follows.

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.

Section 5. What's Covered Under Vision Benefits

The Health Plan's vision benefit 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.

The Health Plan's vision benefits are designed to provide you and your eligible dependents with eye examinations and corrective lenses. The Health Plan's vision benefit 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 medical portion of the Health Plan.

(a) Specialty Lenses and Frames

VSP covers a wide selection of frames, but not all frames will be covered in full. Refer to the section titled *Your Other Expenses* beginning on page 97 for more details.

Any costs for lenses and frames exceeding the Health Plan's vision benefit allowance are the patient's responsibility. However, when a patient selects a frame that exceeds the Health Plan's vision benefit allowance, the additional charges are administered at VSP's controlled costs.

Costs for cosmetic options on lenses and frames are also the patient's responsibility. However, VSP also has controlled costs for cosmetic options, and these charges are typically less than usual and customary fees. You should consult your VSP doctor about lens options that may be cosmetic in nature or exceed the VSP allowance. Again, you do not have to use a VSP doctor, but it may save you money when purchasing designer frames or cosmetic options.

(b) Contact Lenses

If contact lenses are Medically Necessary, they are covered in full with a VSP doctor. Before filling your contact lenses, your provider must request pre-authorization from VSP to confirm Medical Necessity.

Elective contact lenses are covered in lieu of spectacle lenses (*i.e.*, elective contact lenses and spectacle lenses are not covered in the same calendar year). 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). Nevertheless, you are eligible for eyeglass frames once every other calendar year.

Section 6. What's Not Covered Under Vision Benefits

Lenses and frames furnished under the Health Plan's vision benefit which are lost, stolen or broken will not be replaced except at normal intervals when services are otherwise available.

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 medical benefits);
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; and
8. any surgical procedure.

ARTICLE VIII. GENERAL PROVISIONS

This section contains the Health Plan's general provisions, including details on filing claims, the Recovery Incentive Program, third-party reimbursement and administrative details.

This section also contains a statement of your rights as a Health Plan participant, including rights under HIPAA.

Section 1. Things For You To Do

(a) Let Us Know Where You Are

You must keep the Health Plan informed of any changes to your contact information (including phone numbers, mailing addresses and e-mail addresses) to ensure that you receive all Health Plan communications, including important changes that may affect your benefits. You must separately notify the Health Plan of any updates to your contact information, even if you have already notified your Employer.

The Health Plan's address and telephone numbers are:

DGA-Producer Health Plan
5055 Wilshire Blvd.
Suite 600
Los Angeles, California 90036
www.dgaplans.org
(323) 866-2200
(877) 866-2200

(b) Notify the Health Plan if Your Family Status Changes

You must inform the Health Plan of any changes in your family status, such as:

- marriage;
- birth, adoption or guardianship of a child;

- death of a spouse;
- divorce; or
- child ceases to qualify as an eligible dependent child.

(c) Keep Your Records

The accuracy and completeness of your Covered Earnings records are an important factor in determining your eligibility for Health Plan benefits.

You can protect yourself by carefully checking the quarterly and annual statements you receive from the Health Plan as well as any work records you receive from your Employers (e.g., pay vouchers, check stubs and other evidence of employment).

If you discover that you have not received proper credit for Covered Earnings or if your quarterly or annual statement appears to be incorrect, contact the Contributions and Collections Department at the Health Plan as soon as possible at the following phone numbers or address noted previously:

In the Los Angeles Area
(323) 866-2200

Toll-Free Outside Los Angeles
(877) 866-2200

Section 2. Filing a Claim

(a) No Assignments

Unless specifically permitted by the Health Plan and outlined in this Summary Plan Description, the right of any participant to receive any benefits under the Health Plan, including the right to file a lawsuit against the Health Plan, or against any Employer, any Health Plan employee, any Health Plan service provider, any Health Plan agent, the Health Plan Administrator, or any Health Plan fiduciary, may not be assigned to any

third party and such right will not be alienable by assignment. Notwithstanding the foregoing, nothing shall prohibit the Health Plan from entering into any agreements with service providers to assist with the negotiation of Non-Network provider fees on behalf of participants, or from allowing Network providers to bill the Health Plan directly for services provided to participants. Any services for negotiation of Non-Network provider claims are provided to participants solely as a member convenience and may be terminated by the Health Plan in its sole discretion at any time. The payment of benefits may also be made directly to a service provider who has provided medical care to a participant, or to any other third party to whom such person is indebted as a convenience to such person, provided that such person shall remain primarily liable at all times with respect to payment for such medical care or other indebtedness, and such payment shall not imply an enforceable Assignment of Benefits or the right to receive such benefits. No compensation reduction elections or other contributions under this Plan will cause any Employer to be liable for, or subject to, any manner of debt or liability of any participant.

The right of any participant to receive any benefits under the Plan will not be subject to any claims by any creditor of, or Claimant against, the participant; and any attempt to reach such amounts by any such creditor or Claimant, or any attempt by the participant to confer on any such creditor or Claimant any right or interest with respect to such amounts, will be null and void, except as provided in Section 609 of ERISA with respect to Qualified Medical Child Support Orders ("QMCSO").

(b) Medical Claims

Some providers will bill the Health Plan for the Health Plan portion of any claims incurred on your behalf or on behalf of your dependents. This is referred to as Assignment of Benefits.

If you use a Network provider, you do not need to submit a claim to the Health Plan. Your Network doctor, Network Hospital or other Network provider will automatically accept Assignment of Benefits and bill the Health Plan directly. All you have to do is pay the applicable Co-Insurance, Co-Payment and Deductible, if any.

(1) Providers Filing Claims

If your provider already submits claims electronically, give your provider a copy of your Health Plan ID card, which contains billing and electronic submission information.

If your provider does not already submit claims electronically, your provider can contact the Health Plan for more information at **(323) 866-2200** or **(877) 866-2200**.

If your provider is manually filing a claim, they must submit a completed CMS-1500 form for professional services and a UB-92 form for Hospital-related claims.

(2) Filing a Claim Yourself

If you received services from a Blue Cross Network provider, your provider will submit your claim to the Health Plan on your behalf. There is no need to manually submit your claim. The chart on the next page (→) depicts all available claims submission channels.

The graphic on page 104 provides step-by- step instructions for submitting a claim from a Non-Network provider for services received in the U.S.

(3) Medicare-Coordinated Claims

If you visit a Medicare-participating provider in California who will accept an Assignment of Benefits (*i.e.*, the provider will bill Medicare directly for Medicare's portion of the bill), you do not need to submit a claim to the Health Plan. The Health Plan will automatically coordinate payment on this claim with Medicare.

If your provider does not accept Assignment of Benefits (*i.e.*, you pay the bill directly and then request reimbursement from Medicare) or your provider is outside of California, Anthem Blue Cross (for California claims) or Anthem Blue Cross/Blue Shield (for non-California claims), you will need the Explanation of Benefits (EOB) sent to you by Medicare.

(c) Prescription Drug Claims

If you use a Network pharmacy, you do not have to file a claim; it is taken care of by the pharmacy. Be sure to show your CVS Caremark ID 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-Network pharmacy, you will not receive the Network discount; you will have to pay the full amount at

the time of purchase, and you will have to file a claim form with CVS Caremark for your partial reimbursement.

To file a claim, you can obtain a claim form from either www.caremark.com or www.dgaplans.org/forms and submit the necessary information and receipts. You will be reimbursed for the amount that would have been covered at the discounted rate, less the Co-Payment amount.

All prescription drug claim forms should be mailed to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

For questions related to your prescription claims, you can contact CVS Caremark at **(855) 271-6601**.

	Domestic	International
Customer Service	(877) 866-2200, Ext. 401	(800) 810-2583
Fax	(866) 896-1393 (866) 896-6626	(866) 896-6531 (866) 896-6532
	If you have Caller ID Block installed on your phone line, you will need to temporarily disable the feature by dialing *82 before faxing your claim to Blue Cross.	Not available
Email	Not available	claims@bcbsglobalcore.com
Online	www.Anthem.com (You must be a registered user.)	www.bcbsglobalcore.com
Mail	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	BlueCross BlueShield Global Core Service Center P.O. Box 2048 Southeastern, PA 19399
Other	Not available	BlueCross BlueShield Global mobile app (for Android, iPhone and iPad)



How It Works:

Submitting Your Non-Network Medical Claims

Follow the steps below to file a claim from a Non-Network provider for services received in the U.S.

To avoid a delay in the processing of your claim, be sure you have a recent Coordination of Benefits form on file with the Health Plan before submitting your claims to Blue Cross.

1

Download the claim form at www.dgaplans.org/forms/health.

NOTE: For fastest processing, you must include both a completed claim form AND your itemized bill. In lieu of the claim form, an itemized bill may be accepted alone as long as it includes BOTH: (1) the information normally supplied on the claim form; and (2) the required information for the itemized bill (detailed in Step 2).

2

Complete your claim form in its entirety and attach your itemized bill.

Your itemized bill must include the following:

- name and address of provider
(doctor, Hospital, laboratory, ambulance service, etc.);
- name of patient;
- service provided;
- date of service;
- amount charged for each service;
- diagnosis code;
- procedure code; and
- tax ID.

3

Submit your claim.

Online (Recommended):

www.Anthem.com
(You must be a registered user.)

By Mail:

DO NOT submit claims to the Health Plan Office. Mail your claim directly to Blue Cross at the address below:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

By Fax:

Choose one:

(866) 896-1393	(866) 896-6626
(866) 896-6531	(866) 896-6532

When faxing your claim, be sure to keep your fax confirmation sheet for your records.

NOTE: If you have Caller ID Block installed on your phone line, you will need to temporarily disable the feature by dialing *82 before faxing your claim to Blue Cross.

(d) Dental Claims

If you use a Delta Dental dentist (regardless of whether they are in the Delta Dental PPO), 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 are a Delta Dental participant. You may want to show your Delta Dental card that has Delta Dental's address and the Health Plan's group number.

If you do not use a Delta Dental dentist, you (or your dentist) will still 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 Health Plan's website, www.dgaplans.org/forms.
- Indicate if it is a pre-determination 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 of California
P.O. Box 997330
Sacramento, California 95899-7330

If you need a Delta Dental claim form, you can write to Delta Dental at the above address, call them at **(800) 846-7418**, or you may download a claim form from www.deltadentalins.com or www.dgaplans.org/forms.

(e) Vision Claims

If you use a VSP Vision ("VSP") doctor, you do not have to file a claim; it will be taken care of by your doctor. If you do not use a VSP doctor, you will have to file a claim yourself.

All vision claim forms should be sent directly to VSP at:

VSP Vision
Attn: Claims Services
P.O. Box 495918
Cincinnati, OH 45249-5918

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.

Vision claims must be filed within six months of the date of service.

(f) Infertility Claims

You are responsible for submitting all claims for covered services directly to Carrot for reimbursement at: www.get-carrot.com. All claims must include the following information to be eligible for reimbursement: (1) the name of the individual receiving the covered service; (2) the nature/date of the covered service; (3) the amount of the requested reimbursement; and (4) a statement that the covered service has not been reimbursed (and is not eligible for reimbursement) from any other source.

If your claim is denied in whole or in part by Carrot, you or your authorized representative may file an appeal with Carrot. You should submit your written appeal to support@get-carrot.com. If your appeal is denied by Carrot, you can then submit an appeal to the Health Plan for further consideration. The Health Plan will not consider an appeal unless it has already gone through appeal with Carrot. Details regarding how to file an appeal can be found in the *Filing an Internal Appeal* section beginning on page 109.

Section 3. Timely Filing of Network and Participating Provider Claims

Claims filed by any Anthem participating providers, including BlueCard providers, must be submitted to Anthem within their contractually required timely filing period to be eligible for payment. Claims submitted after this date will be denied by Anthem for timely filing. In addition, any Anthem providers who fail to timely submit any claims within Anthem's contractually required timely filing period are precluded from Balance Billing the patient.

Claims from Anthem's non-participating providers, CVS Caremark Network pharmacies, Delta Dental PPO dentists and VSP participating doctors must be submitted as soon as possible after the date the services were incurred.

If it is not reasonably possible to file the claim as soon as possible after the date the services were incurred, the Health Plan will only consider the claim if it is submitted by the earlier of:

- the claims submission deadline provided in the applicable provider policy or procedure; or
- one year after the date of service.

Claims submitted after this date will be denied.

All Infertility claims must be filed directly with Carrot for reimbursement as described in the section titled *Infertility Claims* beginning on page 105. The deadline for submitting Infertility claims to Carrot for reimbursement is the earlier of: (1) 90 days after the end of the calendar year of the date of service; or (2) 30 days after the date your Health Plan coverage terminates (which is the later of the date you lose Earned Active Coverage, Earned Inactive Coverage, regular Carry-Over or related COBRA, as applicable).

Section 4. 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.

(a) Claims in General

A claim means any right asserted by you, your dependent or anyone else asserting a claim on behalf of you or your dependent ('Claimant') under the Health Plan and includes, without limitation, a request for a Health Plan benefit. It also includes a claim arising from the rejection of contributions made on your behalf, which may affect your health coverage or rescission of your health coverage. A request for treatment and diagnosis codes and their corresponding meanings will not be considered an appeal. Claims must be made in writing and submitted to the appropriate office, which depends on the type of claim as further described in this section.

Your claim will be processed in accordance with the Health Plan's claim procedures. How claims are filed and processed depends on the type of claim. Certain claims such as medical, Infertility, prescription, dental or vision benefits must be submitted to the applicable third-party Claim Administrator for the Health Plan. For example, if Anthem Blue Cross, the Health Plan's medical benefit vendor, denies your claim or pre-authorization request for medical services, you must first appeal to Anthem Blue Cross for both the first and second levels of appeal. Only if both appeals are denied by Anthem Blue Cross can you then submit an appeal to the Health Plan for further consideration. The Health Plan will not consider an appeal unless it has already gone through both levels of appeal with Anthem Blue Cross. This process also applies to prescription claims or pre-authorization requests denied by CVS Caremark, the

Health Plan's prescription vendor. In those cases, you must first appeal to CVS Caremark for the first and second levels of an appeal. If both appeals are denied by CVS Caremark, you can then submit an appeal to the Health Plan for further consideration. The Health Plan will not consider an appeal unless it has already gone through both levels of appeal with CVS Caremark. Details regarding how to file an appeal can be found in the *Filing an Internal Appeal* section beginning on page 109. Additionally, claims for benefits must be submitted to the Health Plan office. Each third-party administrator, as well as the Health Plan office, is referred to as a 'Claim Administrator'. Please refer to the provisions under the *Filing a Claim* section beginning on page 101 to determine where and how to file a claim, including obtaining contact information for the 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.

(b) Discretion of the Trustees

The Benefits Committee of the Board of Trustees shall have sole, complete and absolute discretionary authority to, among other things, make any and all findings of facts, constructions, interpretations and decisions relative to the Health Plan, as well as to interpret any provisions of the Health Plan, and to determine among conflicting Claimants who is entitled to benefits under the Health Plan. The Benefits Committee, through the authority delegated by the Board of Trustees of the Health Plan, shall be the sole judge of the standard of proof in all such cases, which means that the Benefits Committee shall have the right to determine the sufficiency of any proof you may provide to support your claim to benefits.

(c) 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.

How and when claims are processed depends on the type of claim. All claims under the Health Plan that are required to be submitted to the Health Plan office are post-service healthcare claims. Most other claims under the Health Plan will also be post-service healthcare claims. If a claim is denied pending receipt of additional information, you have 180 days from receipt of the denial to submit any additional information for consideration and/or to file an appeal of the claim denial.

(d) 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 or claim denial 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 180 days from the date the notice is received to provide the required information or to file an appeal of the claim denial, whichever is applicable. If the claim for benefits is 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.

(e) Pre-Service Health Care Claims

A pre-service claim is a request required by the Health Plan for approval of a healthcare benefit 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 hospitalization, inpatient substance abuse treatment and inpatient mental health treatment which require utilization review by Anthem Blue Cross; substance abuse treatment and inpatient mental health treatment, which require pre-authorization by Anthem Blue Cross; and home use of certain prescription drugs, which require pre-authorization by CVS Caremark. If pre-authorization is required, CVS Caremark will notify the provider. There are three types of pre-service healthcare claims: urgent care claims, non-urgent care claims and concurrent care claims.

(f) Contents of Notice of Decision

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

- the specific reason or reasons for the adverse determination, including the denial code and corresponding meaning;
- a statement that you are entitled to receive, upon request, the treatment code, the diagnosis code and their corresponding meaning;
- 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;
- a statement disclosing the availability of, and contact information for, any applicable

consumer assistance office or ombudsman established to assist individuals with claims and appeals;

- a description of the Health Plan's review procedures (and external review processes when external review is applicable), 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; and
- a statement disclosing the availability of, and contact information for, language assistance available for those who are not proficient in English.

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, or for claims for which the Health Plan must make a determination of disability, the internal rules or guidelines that were applied in making the determination or a statement that such rules or guidelines do not exist;
- 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;
- if the determination affects a claim for urgent health care, a description of the expedited review process applicable to such claims; and
- if the Health Plan must make a determination of disability to decide the claim, a discussion of the decision, including an explanation

of the basis for disagreeing with or not following the views of the healthcare or vocational professionals presented by the applicant or obtained by the Health Plan, or any Social Security Administration disability determination presented by the applicant, as well as a statement that the applicant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records or other information relevant to the claim for benefits.

(g) Filing an Internal Appeal

If a claim filed by a Claimant is denied, you have 180 days from receipt of the denial to submit a written internal appeal. The appeals decision for any claims denied by the Health Plan office will be conducted by the Benefits Committee (“Designated Committee” or “Benefits Committee”), designated in its sole and absolute discretion by 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.

You may submit evidence, written comments and other information relating to the claim for consideration on appeal. The Trustees will consider all of the evidence and testimony submitted in support of your appeal, but you will not be entitled to make an in-person appearance at the meeting. 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. You will be provided, automatically and free of charge, any new evidence considered, relied on or generated during the appeal process. If the Claim Administrator bases its determination on a new rationale, the Claim Administrator will furnish the new evidence or rationale to you, automatically and free of charge, as soon as possible. Any such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the Decision on

Appeal is required to be provided) to give you a reasonable time to respond prior to that date. If the new or additional evidence or rationale is received so late in the claim appeal process that a Claimant would not have a reasonable opportunity to respond, the period for providing the final Decision on Appeal will be delayed until such time as the Claimant has had such an opportunity.

(h) Voluntary Request for Additional Review of Post-Service Claims

With respect to post-service claims, as indicated previously, if a third-party Claim Administrator denies your claim, you must appeal that claim to the third-party Claim Administrator. If the third-party Claim Administrator denies your appeal, you may request review of a post-service claim by the Benefits Committee of the Board of Trustees. This voluntary level of appeal is available only for post-service claims.

Requesting this review of a post-service claim by the Designated Committee of the Board of Trustees is entirely voluntary, and the Health Plan will not assert a failure to exhaust administrative remedies if you choose not to utilize this review process. So long as the Health Plan receives your request for review within 60 days of the date of the decision of the Claim Administrator regarding your appeal, any statute of limitations applicable to pursuing your claim in court will be tolled during the time that any such voluntary appeal is pending.

(i) Decisions on Appeal

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 or evidence 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 or the Designated Committee of the Board of Trustees) 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.

Reviews of denials by the Health Plan office will be heard by the Designated Committee at its next regularly scheduled quarterly meeting. However, if an appeal is received fewer than 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.

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 healthcare professional who has experience and training in the relevant field and who was not involved in the initial determination. The identity of any such healthcare professional will be provided to you upon request and free of charge.

(j) Contents of Notice of Decision on Appeal

Any notice of an adverse determination will include the following:

- information identifying the claim, including the date of service, the healthcare provider and the claim amount;
- the specific reason or reasons for the adverse determination, including the denial code and corresponding meaning;
- a statement that you are entitled to receive, upon request, the treatment code, the diagnosis code and their corresponding meaning;
- 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, including treatment, diagnosis, and denial codes and their corresponding meanings;
- a description of your available internal and external appeal processes, including information on how to initiate such an appeal;
- a statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals; and

- a statement describing your right to bring an action under ERISA Section 502(a).

A notice of an adverse determination will 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;
- if an internal rule, guideline or standard was applied in making the determination, a description of that rule, guideline or standard will be provided free of charge upon request, or for claims for which the Health Plan must make a determination of disability, the internal rules or guidelines that were applied in making the determination or a statement that such rules or guidelines do not exist; and
- for claims for which the Health Plan must make a determination of disability, a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of the healthcare or vocational professionals presented by the applicant or obtained by the Health Plan, or any Social Security Administration disability determination presented by the applicant, as well as a description of any contractual limitations period that applies to the right to bring an action under ERISA Section 502(a) and the calendar date on which the limitations period expires.

(k) Filing an External Appeal

You may have an external appeal right to any adverse benefit determination or final adverse benefit determination involving medical judgment or a rescission of coverage. Your claim is not eligible for external review if it involves a denial, reduction, termination, a failure to provide payment for a

benefit based on a failure to meet the requirements for eligibility under the terms of the Health Plan, or a legal or contractual interpretation of the Health Plan's terms.

If an internal appeal is denied, you have four months from receipt of the denial to submit a written request for external appeal. If there is no corresponding date four months after the date of receipt of such notice, then the written request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, you must file your written request by March 1. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday. Within six business days of receipt of your written request for an external appeal, the Health Plan will send a written notification informing you whether the request is complete and eligible for review, complete but not eligible for review, or incomplete.

If the request is complete and eligible for review, the appeal will be referred randomly to an independent review organization.

If the request is complete but not eligible for review, the notification will include the reasons for such ineligibility and provide the contact information of the Employee Benefits Security Administration.

If the request is incomplete, the notification will describe the information or materials you must provide to complete the request. You will have until the end of the four-month filing period or until 48 hours after receipt of the notification, whichever is later, to provide the appropriate information or materials.

(l) Independent Review Organizations

If the Health Plan advises you that your request for an external appeal is complete and eligible

for review, you will receive a notice from an independent review organization (“IRO”) to which your appeal has been referred stating that it has been accepted for external review. The notice will state that you have 10 business days following receipt of the notice to submit additional information for the IRO’s consideration. The IRO must consider any information that you submit within this period and is permitted, but not required, to consider any information you submit outside the 10-day period. The Health Plan will forward to the IRO all information and documents considered in denying your appeal.

The IRO will promptly forward to the Health Plan any information you submit to the IRO. The Health Plan may, at its discretion, consider such information and reverse its determination. Such consideration will not delay the ongoing external review.

The IRO will not be bound by any decisions made or conclusions reached by the Health Plan and will give such conclusions and decisions no deference. The IRO will consider the following in making its determination, to the extent they are available and appropriate:

- the Claimant’s medical records;
- the attending healthcare professional’s recommendation;
- reports from appropriate healthcare professionals and other documents submitted by the Health Plan, Claimant or the Claimant’s treating provider;
- the terms of the Claimant’s plan;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- any applicable clinical review criteria developed and used by the Health Plan; and
- the opinion of the IRO’s clinical reviewer or reviewers.

(1) Notice from the IRO

Within 45 days of the IRO receiving the request for external review, the IRO will provide written notice of its determination to you and the Health Plan. The notice will contain the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
- the date the IRO received the referral and the date of the IRO’s decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered by the IRO;
- a discussion of the principal reasons for the decision;
- a statement that the decision is binding except to the extent that other remedies may be available under state or federal law;
- a statement that judicial review may be available; and
- current contact information for an office of health insurance consumer assistance.

(2) External Review of Urgent Care Determinations

Where the normal timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or

would jeopardize the Claimant's ability to regain maximum function and you have filed for an expedited internal appeal, the Health Plan will consider immediately, or cause the third party administrator handling your appeal to consider immediately, the completeness and eligibility for review of the claim, and if the claim is complete and eligible, immediately refer such claim to an IRO.

The previous paragraph also applies where the normal timeframe for completion of a normal external appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or where the internal denial of appeal concerns an admission, availability of care, continued stay, or healthcare item or service for which the Claimant received Emergency Services but has not been discharged from a facility.

The IRO in these situations will provide notice as expeditiously as the Claimant's condition and circumstances require, but in no event more than 72 hours after the IRO receives the request for external review. That notice may or may not be in writing, but if it is not, then the IRO will also provide written confirmation within 48 hours of the initial notice.

(3) Reversal by the IRO

If the IRO reverses the Health Plan's determination, the Health Plan will immediately provide coverage or payment for the claim.

(4) Maintenance of Records by the IRO

The IRO will maintain all records of claims and notices associated with the external review process for six years and will make such records available for your examination upon request.

(m) Ongoing Course of Treatment

The Health Plan will not reduce or terminate coverage of an ongoing course of treatment pending the outcome of an appeal without notification sufficiently in advance of such reduction or termination to allow you to appeal.

(n) Exhaustion of Internal Health Plan Procedures

You, your eligible dependent(s) and any other Claimant(s) must first exhaust the Health Plan's internal appeals process before filing a legal action of any kind or nature, in state or federal court, against the Health Plan or the Board of Trustees. This means that you must follow all of the procedures for filing a claim and appeal as described in this Summary Plan Description. If, however, the Claim Administrator fails to substantially comply with the claims and appeals procedures, you may seek judicial review of your claim without first exhausting the Health Plan's claims and appeals procedures.

The internal claims and appeals procedures will not be deemed exhausted based on certain minor violations that are not prejudicial to you, so long as such minor violations are attributable to good cause or matters beyond the control of the Health Plan or the Claim Administrator that occurred in the context of a good faith exchange of information between you and the Health Plan. In addition, such violation cannot be reflective of a pattern of non-compliance. In the event of such minor violation as described above, you may request a written explanation of the violation from the Claim Administrator. The Claim Administrator will respond to such request within 10 days, with a specific description of such violation and why it should not cause the internal claims procedures to be deemed exhausted.

(o) Cooperation with Audits

The Health Plan occasionally conducts audits of Employers to determine, among other things, whether contributions have been properly made on your behalf. You may be asked to provide information or documents to facilitate the Health Plan's review. By participating in the Health Plan, you and all eligible dependents agree to fully cooperate with the Health Plan in connection with such audits and timely providing information and

documents in your possession within 45 days of the Health Plan's request.

(1) 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 your eligibility is based on non-covered employment, the Health Plan will take corrective action. This may include retroactively removing earned eligibility or reducing eligibility (e.g., moving your coverage from the DGA Premier Choice Plan to the DGA Choice Plan), or seeking reimbursement of health benefits paid as a result of such non-covered employment, with thirty days' advance written notice, if you, or someone seeking to obtain coverage for you, performs an act, engages in a practice or commits an omission which constitutes fraud or an intentional misrepresentation of material fact prohibited by the Health Plan or the policy of the Board of Trustees.

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 a partner, a sole proprietor or a member of a limited liability company who is not a bona fide employee of the limited liability company.

Each quarter, the Health Plan mails a statement to you detailing the contributions remitted to the Health Plan on your behalf. When you receive your statement, please review it and contact the Health Plan office if you find any discrepancies.

(p) Limitation on Legal Actions

Notwithstanding any other provisions of the Health Plan, no action may be commenced by you, your dependents or any other Claimant with respect to, or arising out of, any claim for benefits or any other claim of any kind or nature against the Health Plan or against the Trustees after expiration of the Limitations Period described here. The Limitations

Period means that you, your eligible dependents or any other Claimant have one year to take legal action if you believe that the Health Plan has denied rights or benefits you believe you are entitled to receive. The one-year period also applies when an action has been taken that affects your eligibility for, or entitlement to, any benefit under the Health Plan, such as the failure or refusal to recognize any earnings that you believe are Covered Earnings.

Unless you bring a timely appeal from an action of the Health Plan as provided above, this one-year period starts with the earlier occurrence of any of the following:

1. An event occurs that gives you or any Claimant notice that the Health Plan:
 - is not providing you or any Claimant with a benefit;
 - has denied you or any Claimant a claim or a benefit, that you or any Claimant otherwise expected to receive;
 - refuses or fails to recognize any earnings that you believe are Covered Earnings; or
2. Circumstances exist such that you or any Claimant should know that the Health Plan:
 - is not giving you or any Claimant, or is denying you or any Claimant, a claim or a benefit that you or any Claimant believe you are entitled to receive under the Health Plan; or
 - is refusing or failing to recognize any earnings that you believe are Covered Earnings.

If you do bring a timely appeal as outlined, the one-year period will begin when the Health Plan first notifies you of the denial of an appeal you or any Claimant have filed with the Health Plan.

These rules also apply to your eligible dependents.

After the Limitations Period expires, you and any Claimant no longer have the right to take legal action relating to a claim under the Health Plan

for benefits including, without limitation, filing a lawsuit in state or federal court.

The Limitations Period applies to:

- all actions arising out of, or relating to, a claim for benefits including, but not limited to, an action under Section 502(a)(1)(B) of ERISA;
- all actions under Section 502(a)(3) of ERISA if the claim relates to the provision of benefits or rights under the Health Plan;
- all actions regarding eligibility for or entitlement to benefits, including recognition of Covered Earnings; and
- all actions relating to or arising, directly or indirectly, under the Health Plan including, without limitation, legal or equitable claims relating to modification, or loss of eligibility for Health Plan benefits, or any other Health Plan finding or determination affecting you, your eligible dependents' or any other Claimant's benefits or rights under the Health Plan.

This section does not apply to legal actions arising from breaches of fiduciary duties or any other violation of ERISA's general fiduciary and prohibited transaction provisions.

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

(q) Eligibility Appeals

Health Plan eligibility appeals (*i.e.*, appeals not related to a health claim) must be submitted in writing to the Eligibility Department at:

DGA-Producer Health Plan
Attn: Eligibility Manager
5055 Wilshire Blvd.
Suite 600
Los Angeles, California 90036
Email: eligibility@dgaplans.org
Fax: (323) 866-2399

If an appeal is received by the Health Plan office at least 30 days before the next Benefits Committee meeting, the appeal will be presented to the Benefits Committee at its next meeting. If an appeal is received by the Health Plan office fewer than 30 days before the next Benefits Committee meeting, the appeal will be presented to the Benefits Committee at the meeting following the next Benefits Committee meeting.

Section 5. Claims Payments

(a) Overpayments

The Health Plan has the right to recover any mistaken payment, overpayment or any payment made to any individual who was not eligible for that payment. Altogether, these are called "overpayments" or individually an "overpayment."

If your overpayment is the result of, or construed to be the result of, a rescission of your coverage because you, or someone acting on your behalf, performed an act, engaged in a practice or committed an omission which constitutes fraud or an intentional misrepresentation of material fact prohibited by the Health Plan or the policy of the Board of Trustees, you will receive 30 days advance written notice requiring you to reimburse the Health Plan for the overpayment.

The Health Plan has the right to collect an overpayment from you, your eligible dependents or your Employer, or to pursue each or all of you for reimbursement. The Board of Trustees can take all actions it determines to be necessary and appropriate, in its sole and absolute discretion, to recover the overpayment. Such actions may include, but are not limited to, all of the following utilized individually or collectively:

- reducing the amount owed to the Health Plan by applying the amount of contributions made by your Employer during the relevant period;

- entering into a written agreement with you requiring that you repay the overpayment with interest, if applicable; and
- requiring that the amount of the overpayment be deducted from any and all future benefit payments on your claims until the full amount of the overpayment is paid to the Health Plan.

The Board of Trustees shall assess interest on the amount due to the Health Plan because of the overpayment at the rate in effect at the time of the overpayment, as periodically set by the Board of Trustees and may, in its sole and absolute discretion, seek payment of all amounts the Board of Trustees determines you owe through filing a lawsuit or taking any other measure the Board of Trustees deems necessary and appropriate. You, your eligible dependents and your Employer are also responsible for repaying the Health Plan for all expenses incurred collecting the overpayment, including, but not limited to, audit fees, attorneys' fees, costs and interest calculated from the date of the initial overpayment.

(b) Recovery Incentive Program

Whenever you receive a bill or Explanation of Benefits from the Health Plan, be sure to check it carefully.

If you find you have been billed incorrectly, whether due to an overcharge by the provider 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 \$2,500 (50% of \$5,000) or less than \$100.

An overcharge greater than \$5,000 will be reviewed by the Board of Trustees for consideration of an additional incentive over the \$2,500 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.

(c) Forfeitures and Payments to Missing Persons and Providers

If you are entitled to a payment under the Health Plan, your payment will be forfeited if:

- the Health Plan office is unable to locate you; or
- you fail to negotiate payment of your Health Plan check within one year after the Health Plan office mails the payment to you at your last known address shown in the Health Plan's records.

If forfeited, your payment will be applied to offset expenses of the Health Plan and/or pay other participants' or dependents' benefits under the Health Plan.

If you later request payment of your benefit from the Health Plan after the forfeiture has occurred, the Health Plan will reinstate your benefit and pay the benefit (without any interest or any earnings) to you.

The provisions of this subsection also apply to providers and any payments to which providers are entitled under the Health Plan.

(d) Third-Party Reimbursement

"Third party" means a person, organization or entity of any kind which causes injury or Sickness to you or

a dependent or causes you or a dependent to suffer a loss, for which you or a dependent seeks, obtains or is legally entitled to seek or obtain, benefits or compensation for treatment of such injury, Sickness or loss under the Health Plan.

No benefits will be paid on behalf of you or your dependents under any coverage of the Health Plan with respect to an injury, Sickness or loss for which a third party or insurance carrier may be liable or legally responsible unless you and/or your dependent agrees, in writing, to all of the following terms:

- to give the Health Plan written notice promptly whenever a claim against a third party or an insurance carrier is made by, or on behalf of, you or your dependent for damages as a result of an injury, Sickness or loss;
- to grant to the Health Plan a lien to the extent of the benefits paid by the Health Plan, on any and all amounts received from a third party or an insurance carrier as a result of the injury, Sickness or loss suffered or experienced by you and/or your dependent and to execute any and all documents evidencing such lien as requested by the Health Plan. Without limitation, this lien shall apply to any and all amounts received from a third party or an insurance policy applicable to the injury, Sickness or loss, including but not limited to the following types of insurance: liability, workers' compensation, uninsured motorist, underinsured motorist, medical malpractice, professional malpractice, and employment practices liability. The Health Plan's lien shall be prior to, and superior to, the right of any other person or entity, including but not limited to any attorneys' fees or court costs associated with the recovery;
- to execute an assignment in favor of the Health Plan for the amount of the lien;

- to cooperate with the Health Plan in any efforts to collect the amount of the lien from a third party or an insurance carrier;
- to reimburse the Health Plan for the amount of the lien when a recovery is obtained from a third party or an insurance carrier beginning with the first dollar of recovery and in an amount up to, but not exceeding the recovery;
- to maintain separate from, and not co-mingled with any other funds, any amounts received in a recovery from or on behalf of a third party or an insurance carrier; and
- to pursue claims against a third party or insurer who may be liable or legally responsible for the injury, Sickness or loss suffered or experienced by you and/or your dependent, but if you and/or your dependent fails or refuses to pursue such claims, that the Health Plan shall be subrogated to any and all your rights and/or your dependents against the third party or insurer, and that you and/or your dependents shall cooperate fully and completely with the Health Plan in its efforts to obtain recovery against the third party or insurance carrier.

If you and/or your dependent fails to comply with any of the provisions listed previously, the Health Plan may refuse to provide you and/or your dependents with benefits until such conditions are satisfied.

Notwithstanding the foregoing, the Board of Trustees may take such actions as the Board, in its sole and absolute discretion, to make a determination that would best serve the interest of the Health Plan.

The Health Plan has the right of first reimbursement from the amounts paid by a third party or insurance carrier, before attorneys' fees, and even if you and/

or your dependent has not fully recovered, or been made whole, for your and/or your dependent's loss. However, the amount of reimbursement to the Health Plan will not exceed the lesser of:

- the amount actually paid by the Health Plan; or
- the amount of the recovery from or on behalf of the third party or insurance carrier.

Notwithstanding the foregoing, if any payment is made under the Health Plan as a result of any injury or loss caused by a third party, the Board of Trustees may take such actions as the Board, in its sole and absolute discretion, determines would best serve the Health Plan.

Section 6. ERISA Required Information

The following information is required under the Employee Retirement Income Security Act of 1974 (ERISA).

(a) Name of Plan

This Plan is known as the Directors Guild of America–Producer Health Plan ("Health Plan" or "Plan").

(b) Type of Plan

This group health plan is maintained for the purpose of providing medical, prescription drug, dental and vision benefits for participants of the Health Plan and their covered dependents.

(c) Plan Administrator and Sponsor

The Chief Executive Officer ("CEO") of the Health Plan is the Plan Administrator. This means that the CEO is responsible for seeing that information regarding the Health Plan is reported to government agencies and disclosed to you and your dependents in accordance with the requirements of ERISA.

The address of the Plan Administrator is:

Chief Executive Officer
DGA-Producer Health Plan
5055 Wilshire Blvd
Suite 600
Los Angeles, California 90036

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

(d) Name and Address of Board of Trustees

The Board of Trustees consists of an equal number of DGA-appointed and management-appointed representatives, selected by the DGA and the Employers, respectively, in accordance with the Trust Agreement which relates to this Plan.

Correspondence to the Board of Trustees should be addressed to:

DGA–Producer Health Plan
5055 Wilshire Blvd.
Suite 600
Los Angeles, California 90036
(323) 866-2200
(877) 866-2200

As of March 1, 2025 the DGA Trustees of this Plan are:

Mr. Jonathan Avnet
Ms. Yudi Bennett
Mr. Scott Berger
Ms. Marie Cantin
Mr. David Dreyfus
Mr. Valdez Flagg
Ms. Karen Gaviola
Mr. Todd Holland
Mr. Russell Hollander
Mr. Seith Mann
Mr. Jonathan Mostow

Mr. Michael Pressman
Mr. Jay D. Roth
Ms. Liz Ryan
Ms. Mary Rae Thewlis
Ms. Betty Thomas
Mr. Dwight Williams
Mr. Michael Zinberg

As of March 1, 2025, the Producer Trustees of this Plan are:

Ms. Helayne Antler
Ms. Tracy Cahill
Ms. Melinda Carrido Gavron
Mr. Safeer Hopton
Mr. Harry Isaacs
Mr. Sheldon Kasdan
Mr. Hank Lachmund
Ms. Nicole Lang
Ms. Ruby Little
Ms. Carol A. Lombardini
Mr. Matthew Miller
Mr. Joseph Pitra
Mr. Robert Sacks
Ms. Natasha Shum
Mr. Seth Stevelman
Ms. Rosemarie Unite

(e) IRS Identification Numbers

The taxpayer identification number assigned to the Health Plan by the Internal Revenue Service is 23-7067289. The Health Plan Number is 501.

(f) Agent for Service of Legal Process

The name and address of the agent designated for the service of legal process is:

Chief Executive Officer
DGA—Producer Health Plan
5055 Wilshire Blvd.
Suite 600
Los Angeles, California 90036

Legal process may also be served on a Plan Trustee at the aforementioned address.

(g) Collective Bargaining Agreements

Contributions to the Health 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 and at www.dga.org.

(h) Source of Contributions

The benefits described in this book are provided through Employer contributions to this Plan as well as your 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 your Covered Earnings. The minimum earnings threshold will generally 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 your behalf for working under a Collective Bargaining Agreement.

(i) Trust Fund

Benefits are provided from the Health Plan's assets, which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to you and your beneficiaries and defraying reasonable administrative expenses. All self-funded benefits are provided directly through the Trust Fund.

The Health Plan can be amended or terminated at any time by the Board of Trustees. In the event of

the Termination of the Health Plan, the Trustees shall apply the Health Plan's assets solely towards the purpose of paying, or providing for the payment of, obligations created under the Health Plan, including but not limited to, purchasing insurance contracts on the behalf of any participants or beneficiaries entitled to benefits under the Health Plan or transferring funds to a successor trust having the same or similar purpose as the Health Plan. The Trustees shall have the sole discretion to distribute the balance of the Health Plan's remaining assets in any manner that they determine will carry out the purpose of the Health Plan. In no event shall any part of the corpus, income or contributions of the Health Plan be used for, or diverted to, purposes other than for the exclusive benefit of the participants and beneficiaries, the administrative expenses of the Health Fund, or for any other payments in accordance with the provisions of the Health Plan. Under no circumstances shall any portion of the corpus, income or contributions to the Health Fund directly or indirectly revert or accrue to the benefit of any Employer, the Directors Guild of America or participant upon Termination of the Health Plan.

(j) Identity of Providers of Benefits

The medical, prescription drug, dental and vision benefits are self-funded and are provided by the Health Plan. The PPO Network in California is provided by Anthem Blue Cross. The PPO Network outside California is provided by Anthem Blue Cross' BlueCard. Vision care benefits are provided by VSP Vision. Dental benefits are provided by Delta Dental Plan of California. Prescription drug benefits are provided by CVS Caremark. Inpatient mental health and chemical dependency benefits and outpatient Network mental health benefits are provided by Anthem Blue Cross. Anthem Blue Cross, Anthem Blue Cross' BlueCard, VSP Vision, Delta Dental and

CVS Caremark provide some administrative services to the Health Plan but do not guarantee benefits. The Health Plan is fully liable for all benefits properly payable under the Health Plan.

(k) Plan Year

The Plan Year is the calendar year (*i.e.*, January 1 – December 31).

Section 7. Your Rights Under ERISA

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

(a) 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 Health 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 Health 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 make a reasonable charge for the copies.
- Receive a summary of the Health Plan's annual financial report. The Plan Administrator is

required by law to furnish each participant with a copy of this summary annual report.

(b) Continue Group Health Coverage

- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the Health 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 Health Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduction or elimination of exclusionary periods or coverage for pre-existing 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

(c) 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.

(d) 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 aforementioned 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 after you complete the Health Plan's claims and appeals procedures. In addition, if you disagree with the Health 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 Health 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.

(e) Assistance with Your Questions

If you have any questions about the Health 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 Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC. 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 toll free at **(866) 444-3272**.

Section 8. HIPAA Privacy Provisions

The provisions of this section shall apply only to those portions of the Health Plan which are considered a group health plan under the Standards for Privacy of Individually Identifiable Health Information (the “Privacy Rule”) under the Health Insurance Portability and Accountability Act of 1996. Thus, the Health Plan is a hybrid entity under the Privacy Rule and only the following health care components are subject to the Privacy Rule:

- medical plan benefits;
- prescription drug plan benefits;
- dental plan benefits; and
- vision plan benefits.

Additionally, this section only addresses the extent to which the Health Plan may disclose Protected Health Information (“PHI”) to the Board of Trustees.

The Health Plan shall not disclose PHI to the Board of Trustees, nor provide for or permit the disclosure of PHI to the Board of Trustees by a health insurance issuer or HMO with respect to the Health Plan, except in accordance with this section or as otherwise permitted by law.

(a) Summary Health Information

The Health Plan, or a health insurance issuer or HMO with respect to the Health Plan, may disclose summary health information to the Board of Trustees, if the Board of Trustees requests the summary health information for the purpose of:

- obtaining premium bids from health plans for providing health insurance coverage under the Health Plan; or
- modifying, amending or terminating the Health Plan.

(b) Enrollment Information

The Health Plan, or a health insurance issuer or HMO with respect to the Health Plan, may disclose to the Board of Trustees information as to whether an individual is enrolled in or has disenrolled in the Health Plan.

(c) Plan Administration Functions

The Health Plan, or a health insurance issuer or HMO with respect to the Health Plan, may disclose PHI to the Board of Trustees to permit the Board of Trustees to carry out plan administration functions for the Health Plan, subject to the provisions of this section.

The Health Plan, or a health insurance issuer or HMO with respect to the Health Plan, will disclose PHI to the Board of Trustees only upon receipt of a certification by the Board of Trustees that Plan Documents have been amended to incorporate the provisions of this section and the Board of Trustees agrees to abide by this section.

The Board of Trustees agrees, with respect to PHI disclosed to the Board of Trustees by the Health Plan, that the Board of Trustees shall, other than as permitted or required by applicable law:

- not use or further disclose the PHI other than as permitted or required by the Health Plan Documents, as amended or as required by law;

- ensure that any agents, including a subcontractor, to whom it provides PHI, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees, provided, however, that PHI does not include employment records held by the Health Plan in its role as Employer;
- report to the Health Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted under this section;
- to the extent, if any, the Board of Trustees maintains PHI, make available to an individual PHI about that individual, to the extent required by the Privacy Rule;
- to the extent, if any, the Board of Trustees maintains PHI, make available to an individual PHI about that individual for amendment and incorporation of any amendments to the PHI, to the extent required by the Privacy Rule;
- track disclosures it makes of PHI and make available to an individual an accounting of such disclosures during the six years prior to the date on which the accounting is requested, to the extent required by the Privacy Rule;
- make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with this Article;
- if feasible, return or destroy all PHI received from the Health Plan that the Board of Trustees maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board of Trustees shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that adequate separation between the Health Plan and the Board of Trustees is established in accordance with the following rules:
 - ◊ The Trustees shall be given access to the PHI as necessary to perform Plan administrative functions.
 - ◊ Any incidents of non-compliance by a Trustee with the provisions of this section shall subject such individual to disciplinary action and sanctions, including the possibility of removal from the Board. The Board of Trustees will report such non-compliance to the Health Plan and will cooperate with the Health Plan to correct the non-compliance, impose an appropriate disciplinary action or sanction, and mitigate the effect of the non-compliance.

The Health Plan shall purchase insurance, with recourse against the Trustees, in favor of the Health Plan insuring against any acts or omissions of the Trustees in violation of their fiduciary duties. The individual Trustees may purchase a waiver of such recourse or other policy of insurance protecting against such recourse, as long as the purchase is not made from assets of the Health Plan.

Section 9. 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.

Section 10. Non-Discrimination Notice

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

The Health Plan provides free aids and services (such as qualified interpreters and information in alternative formats) when necessary to ensure equal opportunity for individuals with disabilities, and free language assistance services (such as translated documents and oral interpretation) when necessary to provide meaningful access to individuals with limited English proficiency. If you need these services, contact the Health Plan's Civil Rights Coordinator at:

Mail: Directors Guild of America—Producer
Pension and Health Plans
Attn: Civil Rights Coordinator
5055 Wilshire Blvd.
Suite 600
Los Angeles, CA 90036

Phone: (323) 866-2233
Fax: (323) 866-2248

If you believe the Health Plan has failed to provide these services or has otherwise discriminated on the basis of race, color, national origin, sex, age or disability, you may file a written grievance with the Health Plan's Civil Rights Coordinator as soon as possible at the address listed above. If you need help filing a claim, please contact the Civil Rights Coordinator for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW,

HHH Building, Washington, DC 20201, **(800) 368-1019, (800) 537-7697** (TDD). Complaint forms are available at <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html>.

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

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

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-866-2200.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-877-866-2200번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-866-2200**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-866-2200**.

إذا اكنت تتحدث بالعربي، فإذن خدمات
اللغوية تتوافر لك بالمجان. اتصل ملحوظة:
بـ رقم **1-866-877-2200** اللمساعد

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-866-2200**.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-866-2200**.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-866-2200**.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-877-866-2200**.

ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-866-2200**.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

1-877-866-2200まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-866-2200**.

توجه: اگر بله زبان فارسی گفتگو می کنید،
تسهیلات زبانی بصورت رایگان برای شما فراهم
می باشد. با **2200-866-877-1** تماس بگیرید

Section 11. A Final Word

This Summary Plan Description for the Health Plan, and, together with the Trust Agreement, is the Health Plan Document. It describes the medical, prescription drug, dental and vision care benefits under the Health Plan that are available to you and your eligible dependents.

(a) Plan Administration

An equal number of Trustees on the Board of Trustees are appointed by the Directors Guild of America, Inc. and by the Producers, as that term is defined in Article I, Section 2 of the Trust Agreement. The operation and administration of the Health Plan is the joint responsibility of the Trustees who constitute the Board of Trustees. However, the Board of Trustees may designate in writing persons who are not Trustees to carry out fiduciary or non-fiduciary duties as long as the designation complies with federal law and all applicable provisions of the Trust Agreement. The Board of Trustees may also allocate in writing fiduciary and non-fiduciary responsibilities or duties among the Trustees or to committees and subcommittees of the Board of Trustees.

The Board of Trustees may establish such committees as the Board of Trustees in its discretion deems proper and desirable for the administration of the Health Plan. These committees may study and debate issues and may make recommendations to the Board of Trustees for action. Such committees may also take final

action in specified areas as authorized by a duly adopted resolution of the Board of Trustees. When final action is authorized and taken as specified in Article IV of the Trust Agreement, then such action taken by a committee shall have the same binding effect as an action by the full Board of Trustees. The standing committees of the Board of Trustees are the Administrative Committee, the Benefits Committee, the Finance Committee, and the Legal and Delinquency Committee. Other committees for special purposes may be created from time to time by resolution duly adopted by the Board of Trustees. All such committees shall have the authority and responsibilities as described in Article IV, Section 9, of the Trust Agreement and as specified by the Board of Trustees by duly adopted resolution.

The Board of Trustees may also allocate and delegate to the Chief Executive Officer ("CEO") such administrative duties and fiduciary responsibilities as the Board of Trustees deems appropriate from time to time. The CEO and the Health Plan staff shall be principally responsible for the day-to-day administration of the Health Fund and the Health Plan as determined by the Board of Trustees. Unless the Board of Trustees determines otherwise, the Chief Executive Officer and staff shall have the authority and responsibilities described in Article IV, Section 2 and Section 8, of the Trust Agreement.

(b) 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 state or federal law. Furthermore, the Board of Trustees reserves the right to impose such restrictions upon the payment of further benefits to you or your dependents 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. You or your dependents 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 you became eligible for Health Plan benefits as a result of earnings which are determined to be non-Covered Earnings, your coverage could be cancelled immediately. Also, to the extent permitted by law, you may be obligated to refund to the Health Plan all benefits received on your behalf in excess of contributions paid by your Employer. If you lose pension credit as a result, improper pension contributions may also be utilized as an offset against benefits paid on your behalf.

(c) Employer Contributions

The Health Plan is funded by contributions made pursuant to Collective Bargaining Agreements between Employers and the DGA. The detailed rules describing the contributions are in Article III of the Trust Agreement. You will also find information about the required contributions in Collective Bargaining Agreements. Eligibility for benefits and Health Plan participation are 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.

***Important Information:** First, not all earnings are reportable to the Health Plan. Certain Collective Bargaining Agreements limit reportable earnings and residuals to an amount different from your actual earnings and residuals. Refer to the applicable Collective Bargaining Agreement (available at www.dga.org/Contracts/Agreements.aspx) that governs your project type and job category to verify the accuracy of earnings and residuals reported on your behalf. Second, contributions must be paid to the Health Plan by your Employer on your DGA-Covered Earnings

or reportable residuals to become eligible for coverage.

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**.

(d) 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 Board of Trustees reserves 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 Board of Trustees and cannot enlarge or change such benefits or eligibility rules.

In accordance with the terms of the Trust Agreement, the Board of Trustees reserves 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 Summary Plan Description can be amended or terminated at any time by the Board of Trustees. These are not guaranteed benefits.

(e) Amendment of the Health Plan

The Board of Trustees has the sole, complete and discretionary authority to alter or amend the Health Plan in its absolute discretion, including the authority to reduce or discontinue benefits to the extent permitted by law and applicable regulations.

The amendments adopted by the Board of Trustees shall be final and binding on all persons and can only be changed by subsequent action by the Board of Trustees.

The provisions of Article V of the Trust Agreement shall govern the procedure for adoption of any amendment to the Health Plan. Amendments can be adopted at regular meetings, special meetings or meetings of the Board of Trustees conducted by electronic communication as long as the procedures of Article V, Section 2 of the Trust Agreement are followed and the Board of Trustees has a quorum as described in Article V, Section 4 of the Trust Agreement. The Board of Trustees can also amend the Health Plan without a meeting provided that such action is evidenced by an instrument in writing to which all of the Trustees consent by unanimous written concurrence. Voting by the Trustees on any amendment shall be governed by Article V of the Trust Agreement, particularly Article V, Section 5 and Section 6.

No amendment or change in the Health Plan may be adopted which will conflict with the then existing Collective Bargaining Agreements or be a violation of any applicable law or governmental rule or regulation. Except as provided by law, no amendment may be adopted which will cause any of the assets of the Health Fund to be used for, or diverted to, purposes other than those authorized by the Trust Agreement, except any amendment may be made which is required to retain the tax-exempt status of the Health Fund.

ARTICLE IX. 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 Summary Plan Description.

Accident/Accidental

An Accident injury, as it applies to benefits, means an injury resulting from an event that happens by chance and without apparent or deliberate cause.

Acupuncture

Acupuncture means the stimulation of a point or points on or near the surface of the body by the insertion of needles, and any other covered treatment or supplies provided by a person licensed to provide Acupuncture under state regulations.

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.

All-Inclusive Network Out-of-Pocket Limit

The All-Inclusive Network Out-of-Pocket Limit is an annual limit amount that you and your eligible dependents have to pay out-of-pocket for Network essential health benefits.

Allowable Charge

The Allowable Charge is the maximum amount that the Health Plan will pay for each covered medical procedure or service. In the case of charges billed by a Non-Network provider, the Allowable Charge is generally the lesser of:

- the provider's charge; or
- the applicable percentage payable of the Reasonable and Customary Allowed Amount.

For some procedures and services, the Allowable Charge is based on the Reasonable and Customary Allowed Amount. For other procedures and services, it is based upon an amount set in the Health Plan.

For example:

The maximum Allowable Charge for Chiropractic Care is \$50 per visit.

Ambulatory Surgical Center

An Ambulatory Surgical Center is a facility that operates for the purpose of providing surgical services to patients not requiring hospitalization.

Ancillary Services

Ancillary Services are:

- items and services related to Emergency Services, anesthesiology, pathology, radiology and neonatology, whether provided by a Physician or non-Physician practitioner;
- items and services provided by assistant surgeons, hospitalists and intensivists;
- diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary of Health and Human Services; and
- items and services provided by a Non-Network provider if there is no Network provider who can furnish such item or service at such facility.

Assignment of Benefits

Assignment of Benefits occurs when you authorize a provider to bill the Health Plan for the Health Plan portion of any claims incurred on your behalf or on behalf of your dependents.

Balance Billing

When a provider bills you for the difference between the provider's charge and the Allowable Charge. Network providers may not balance bill you for Covered Expenses. Non-Network providers can balance bill you for any amounts not covered by the Health Plan, except with respect to Emergency Services, Emergency or non-Emergency Services from a Non-Network provider at certain Network facilities, and air ambulance services furnished by Non-Network providers.

If you believe you have been wrongly billed, or otherwise have complaint, you may contact the Health Plan at **(877) 866-2200** or EBSA's toll free number at **(866) 444-3272**.

Benefit Period

The 12-month period during which a participant is eligible for coverage under the Health Plan.

Biofeedback Training/Therapy

Biofeedback Training/Therapy means a technique intended to teach patients self-regulation of certain physiologic functions not normally considered being under voluntary control. To determine which conditions are covered for Biofeedback treatment, you may contact the Health Plan office.

Biofeedback Training/Therapy for psychiatric diagnoses will be covered if Medically Necessary. Biofeedback for migraine and tension headaches may be covered under the therapy benefit (see the *Therapy* section beginning on page 76 for more information).

Carry-Over Coverage

With sufficient contributions, you can accumulate Carry-Over Credit that can be used to qualify for health coverage in a future Earnings Period in which your Covered Earnings are below the minimum earnings requirement for Earned Coverage. A full year of Carry-Over Credit is used at the time that you start Carry-Over Coverage. A maximum of three years of Carry-Over Coverage can be credited at any given time.

Claim Administrator

Claim Administrator refers to any entity that administers a claim or appeal, per Health Plan Rules. This might include the Health Plan, its benefit vendors or any third party designated by the Health Plan.

Certified Retiree Coverage

You gain Certified Retiree status when you meet all of the requirements listed in the section titled *Certified Retiree Coverage* beginning on page 25. As a Certified Retiree, you and your spouse receive health coverage under the Health Plan for a premium for the rest of your lives or until the benefit is no longer offered by the Health Plan.

Chiropractic Care

Chiropractic Care means all covered services apart from musculoskeletal X-rays provided by a chiropractor, including evaluation, management, chiropractic manipulative treatment, and physical medicine or rehabilitation.

Claimant

Claimant means an individual or entity asserting a claim on behalf of you or your dependents.

COBRA

COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Coverage

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 qualifying events.

Co-Insurance

Co-Insurance is your share of the costs of a covered healthcare service at a percentage of the allowed amount for the service once your annual Deductible has been met.

For example:

For Network benefits under the DGA Premier Choice and DGA Choice Plan, the Health Plan pays 90% of covered services. Your Co-Insurance is 10%.

Co-Insurance Maximum

The Co-Insurance Maximum is the maximum amount on the Co-Insurance that you are required to pay.

Collective Bargaining Agreement

A Collective Bargaining Agreement is the agreement or agreements in force and effect from time to time between the Directors Guild of America and Employers.

This Summary Plan Description covers benefits for Collectively Bargained participants, Non-Collectively Bargained participants and Assistant Director Trainees. There is an additional supplement for Non-Collectively Bargained participants, which includes individuals employed directly by the Directors Guild of America or the Directors Guild of America—Producer Pension and Health Plans.

Assistant Director Trainees qualify for coverage based on the rules of the Assistant Director Training Program. If you are a Trainee, please contact the Assistant Director Training Program office for details.

Complementary and Alternative Medicine

Complementary and Alternative Medicine means a group of diverse medical and healthcare 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

Complications of Pregnancy means:

- conditions requiring Hospital confinement (when the pregnancy is not terminated), the diagnoses of which 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;
- non-elective caesarean section;
- ectopic pregnancy which is terminated; or
- spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

False labor, occasional spotting, Physician-prescribed rest, morning Sickness, hyperemesis gravidarum and pre-eclampsia are not considered Complications of Pregnancy.

Continuing Care Patient

Continuing Care Patient means an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;

- is scheduled to undergo non-elective surgery from the provider, including receipt of post-operative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be Terminally Ill (as determined under Section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Co-Payment

A Co-Payment is a fixed amount you pay for a covered healthcare service, usually paid at the time you receive the service.

Cosmetic Surgery

Cosmetic Surgery is any reconstructive surgery that attempts to change physical appearance and: (1) does not simultaneously correct or improve some disease or bodily impairment; or (2) does not constitute Medically Necessary transgender related treatment to the extent required under Section 1557 of the Affordable Care Act.

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 healthcare expenses incurred in connection with the service or supply.

Cost-Sharing

Cost-Sharing means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the Health Plan. Cost-Sharing generally includes Co-Payments, Co-Insurance and amounts paid towards

Deductibles, but does not include amounts paid towards premiums, Balance Billing by Non-Network providers, or the cost of items or services that are not covered under the Health Plan.

Covered Earnings

Covered Earnings means compensation paid to you 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

Covered Expenses means Hospital, medical, dental, vision and prescription drug costs that are reimbursable under the Health Plan. The Health Plan will not reimburse any Covered Expenses that exceed the Allowable Charges.

Custodial Care

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:

- preparing special diets;
- supervising medication that can be self-administered; or
- assisting the person in getting in or out of bed; to walk; to bathe; to dress; to eat; or to use the toilet.

CVS Caremark Mail Service

CVS Caremark's Mail Service Pharmacy, also referred to as Maintenance Choice, is the Health Plan's prescription drug mail order service. For more information, please refer to the section titled *CVS Caremark Maintenance Choice for Long-Term Maintenance Medications* beginning on page 84.

Deductible

The Deductible refers to the amount of Covered Expenses you must pay before the Health Plan will pay any benefits.

Durable Medical Equipment

Durable Medical Equipment is equipment that satisfies all the following conditions:

- it can stand repeated use;
- it is primarily and customarily used to serve a medical purpose;
- it generally is not useful to a person in the absence of illness or injury;
- it is appropriate for use in the home; and
- it is the most Cost-Efficient equipment that meets the Medically Necessary needs of the patient.

Elevators, stair-lifts, wheelchair ramps or lifts, stair-climbing wheelchairs, specially designed chairs or car seats for back patients, bedside tables, or similar items for comfort or convenience are not considered to be Durable Medical Equipment.

Earned Coverage

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 and Employers in the motion picture, television, and commercial production industries and for which contributions are due to the Health Plan.

Earnings Period

The 12-month work period that determines whether your Covered Earnings are equal to or greater than the applicable minimum earnings threshold for Earned Coverage.

Emergency Services

See *What's Covered Under Medical Benefits*, item (i) *Emergency Services* on page 66.

Employer

A person or entity signatory to a Collective Bargaining Agreement with the Directors Guild of America. Employer also means the Directors Guild of America and the DGA-Producer Pension and Health Plans in their capacity as Employers required to make contributions to the Health Plan.

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:

- the procedure, treatment, supply, device, equipment, facility or drug has final approval from the appropriate government regulatory bodies;
- the scientific evidence permits conclusions concerning the positive effect of the technology on health outcomes;
- the evidence in favor of it consists 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 supporting it are evaluated according to the scientific quality of the supporting evidence and rationale;

- the procedure, treatment, supply, device, equipment, facility or drug improves the net health outcome. Its beneficial effects should outweigh any harmful effects;
- the procedure, treatment, supply, device, equipment, facility or drug is as beneficial and as Cost-Efficient as any established alternatives; and
- the improvement related to its use 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.

Extended Self-Pay Coverage

Extended Self-Pay Coverage is self-pay coverage for a non-retired, non-disabled participant beyond the initial COBRA Coverage period. This is distinguished from COBRA self-pay coverage and Retiree Coverage.

Health Plan or Plan

Health Plan or Plan means the DGA-Producer Health Plan. The Health Plan is subject to change or termination by the Board of Trustees at any time.

Hospice

Hospice means an agency which provides medical, healthcare services and Medical Social Services for

the supportive care and treatment of Terminally Ill individuals.

Hospital

Hospital means an establishment which:

- holds a license as a Hospital (if required in the state);
- operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
- provides around-the-clock nursing service;
- has a staff of one or more Physicians available at all times;
- provides organized facilities for diagnosis and surgery;
- is not primarily a clinic, nursing, rest or convalescent home or a similar establishment; and
- 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.

Illness

Any bodily Sickness or disease, including any congenital abnormality of an eligible newborn child,

as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be considered to be an Illness only for the purpose of coverage under this Plan. Affordable Care Act ("ACA") mandated preventive services for a pregnant dependent child will be covered by this Plan, but not ultrasounds and other non-ACA mandated pregnancy-related services rendered to the pregnant dependent child, including the delivery and/or newborn expenses. 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. Notwithstanding the foregoing, the Health Plan will also cover expenses for a participant, dependent, spouse or dependent child in connection with the termination of a pregnancy as provided in the section titled *What's Covered Under Medical Benefits*, subsection: (q) *Maternity Care* beginning on page 70.

Independent Freestanding Emergency Department

An Independent Freestanding Emergency Department is a healthcare facility that is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services.

Infertility

Infertility treatment that is covered by the Health Plan means procedures and services to overcome an inability to have children as indicated by a medical diagnosis of Infertility. Infertility treatment must be provided and supervised by a Carrot provider.

Examples of covered Infertility treatment include, among others:

- Infertility consultations;
- semen analysis;
- short-term fertility preservation for males and females (for example, short-term egg freezing

or semen freezing if scheduled to undergo a procedure that may result in loss of fertility, such as radiation or chemotherapy);

- genetic testing related to Infertility;
- intrauterine insemination;
- in vitro fertilization;
- transportation of reproductive material with an approved vendor;
- short-term storage costs for eggs, sperm, and/or embryos; and
- Infertility medications.

Examples of non-covered Infertility treatment include, among others:

- any Infertility treatment provided by a non-Carrot provider;
- any Infertility treatment without a medical diagnosis of Infertility;
- long-term Infertility preservation, including egg or sperm freezing;
- expenses related to surrogacy or adoption;
- Infertility related treatments under the care of primary care providers or OB/GYNs;
- herbal treatments;
- nutrition counseling;
- general genetic tests; and
- Physical Therapy or fitness related expenses.

For Health Plan purposes, "short term" shall mean up to a maximum of one year, and "long term" shall mean one year or longer.

Intensive Care Unit

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

Interdisciplinary Team means the primary care unit which develops the overall plan of care and provides for the patient and their immediate family. The team must consist of a Physician and a licensed registered nurse. The team may also contain a registered nurse or licensed practical nurse 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).

Kid's COBRA

Kid's COBRA is the special self-pay coverage offered to the dependent children of retirees who lose dependent status when you are on Retiree Coverage. This coverage is available to eligible dependent children up to age 26.

Medical Social Services

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:

- assessment of the social, psychological and family problems related to or arising from the illness and treatment; and
- appropriate action and utilization of community resources to assist in resolving such problems.

Medically Necessary/Medical Necessity

A treatment, service or supply is Medically Necessary when it is:

- consistent with generally accepted medical practice within the medical community for the diagnosis or direct care of symptoms, sickness or injury of the patient, or for routine screening examination under wellness benefits, 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);
- ordered by the attending licensed Physician (or in the case of dental services, ordered by the dentist), and not solely for your convenience, your Physician, Hospital or other healthcare provider;
- consistent with professionally recognized standards of care in the medical community with respect to quality, frequency and duration; and
- the most appropriate and Cost-Efficient treatment, service or supply that can be safely provided, at the most Cost-Efficient and medically appropriate site and level of service.

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 will be considered Medically Necessary when all of the following conditions are met:

- the drug is approved by the Food and Drug Administration;
- 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

- the drug is Medically Necessary to treat the specific medical condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Also see the section titled *Off-Label Drug Use* on page 88 for more information.

Medicare

Medicare is insurance that is provided by the Federal Health Insurance for the Aged and Disabled Act. Medicare is administered by the Centers for Medicare and Medicaid Services.

Midwife

Midwife means a state-licensed Midwife or a licensed registered nurse 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.

Network

A group of doctors, Hospitals and other providers that have agreed to become part of a Preferred Provider Organization and to charge a reduced rate when their services are used by you.

Non-Network

Doctors, Hospitals and other providers that do not belong to the Health Plan's Preferred Provider Organization and have not agreed to charge a reduced rate.

Non-Network Emergency Facility or Non-Participating Emergency Facility

Non-Network Emergency Facility means an emergency department of a Hospital or an Independent Freestanding Emergency Department (or a Hospital, with respect to Emergency Services as defined) that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

Occupational Therapy

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.

Off-Label Drug Use

Off-Label Drug Use is defined as the use of a drug approved by the United States Food and Drug Administration ("FDA") 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.

Also see definition of *Medically Necessary* on page 136.

Open Enrollment Period

The Open Enrollment Period is the 30-day period during which you may make certain changes to your coverage.

If you are on Earned Coverage, the Open Enrollment Period is the first 30 days of your Benefit Period.

If you are on COBRA Continuation Coverage or Extended Self-Pay Coverage, the 30-day Open Enrollment Period begins on the first day of the month in which the yearly anniversary of that coverage occurs.

If you are on Retiree Coverage, the 30-day Open Enrollment Period begins on the yearly anniversary of your Retiree Coverage. See section titled *Making Changes to Your Health Coverage* for more details on page 14.

Out-of-Pocket Limit

The Out-of-Pocket Limit is the maximum amount of Covered Expenses that you are required to pay after Deductibles, Co-Payments and Co-Insurance.

Palliative Care

Palliative Care means a recognized medical specialty for the care and support of persons with serious, chronic and life-threatening conditions, which can be provided at any stage in an illness and aims to improve the quality of life for both the patient and the family.

Physical Therapy

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

Physician means a licensed practitioner of the healing arts acting within the scope of his/her license.

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.

PPO

PPO stands for Preferred Provider Organization. Providers that belong to the Health Plan's Preferred Provider Organization are considered Network providers.

Psychiatric Disorders

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, and the Diagnostic and Statistical Manual of Mental Disorders.

Qualifying Payment Amount (QPA)

Qualifying Payment Amount (QPA) means generally the median contracted rates of the plan or issuer for the item or service in the geographic region.

Reasonable and Customary Allowed Amount

A Reasonable and Customary Allowed Amount, commonly referred to as "R&C," only applies to Non-Network claims, other than Non-Network Emergency Services, Emergency or non-Emergency Services from a Non-Network provider at certain Network facilities, and Non-Network air ambulance services.

A Reasonable and Customary Allowed Amount is a charge or fee that is equal to the lesser of: (1) actual billed charges; (2) 150% of the applicable Medicare reimbursement rate for a specified procedure; or (3) in the event there is no Medicare reimbursement rate for a specified procedure or it cannot be determined based on the information submitted, the amount that would be paid to a similar provider for the same or similar service or item in the same geographic location or locality. Schedules of maximum Reasonable and Customary Allowed Amounts are adjusted periodically to reflect changes in Physicians' charges.

Recognized Amount

For items or services furnished by a Non-Network provider or Non-Network Emergency Facility,

Recognized Amount means (in order of priority) one of the following:

- an amount determined by an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act;
- an amount determined by a specified state law; or
- the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

For air ambulance services furnished by Non-Network providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Retiree Coverage

The following types of coverage are considered Retiree Coverage:

- Retiree Carry-Over Coverage; and
- Certified Retiree Coverage.

Retiree Carry-Over Coverage

Self-pay coverage for retired participants who have accrued at least one Retiree Carry-Over Credit. You must meet all of the requirements listed in the *Retiree Carry-Over Coverage* section beginning on page 23.

Serious and Complex Condition

Serious and Complex Condition means one of the following:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a condition that:
 - a. is life-threatening, degenerative, potentially disabling or congenital; and

- b. requires specialized medical care over a prolonged period of time.

Sickness

Sickness means illness or disease which causes a 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 you and your covered spouse for the purpose of determining benefits. Pregnancy of your child who is otherwise a covered person is not covered, except for Complications of Pregnancy, preventive screenings as mandated by the Affordable Care Act, and expenses for termination of a pregnancy as provided in the section titled *What's Covered Under Medical Benefits*, subsection: (q) *Maternity Care* on page 70.

Special Enroll or Special Enrollment Right

Special Enroll or Special Enrollment Right refers to the right you and/or your dependents have to enroll in the Health Plan outside the Open Enrollment Period upon the occurrence of certain events.

Special Enrollment Period

The Special Enrollment Period is the period during which you or your dependents can make a change to your coverage under the Health Plan due to events that trigger a Special Enrollment Right. Individuals who enroll during this time are treated the same as individuals who enroll when first eligible during the Open Enrollment Period.

Terminally Ill

You are considered Terminally Ill if you have a medical condition for which no effective treatment exists (or for which known effective treatments have been tried without success) and you are certified by

a Physician as unlikely to survive for a specific length of time. For Hospice benefits, the life expectancy must be six months or less.

Termination

In the context of Continuity of Care, Termination includes, with respect to a contract, the expiration or non-renewal of the contract, but does not include a Termination of the contract for failure to meet applicable quality standards or for fraud.

Trustees

Trustees means the Board or Trustees (and its respective authorized agents) as established and constituted from time to time in accordance with the Health Trust Agreement.

Uniformed Service(s)

Uniformed Service means service rendered by you in any branch of the United States uniformed forces as further defined in the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, Section 4301, et seq.

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Directors Guild of America—Producer Pension and Health Plans
5055 Wilshire Blvd
Suite 600
Los Angeles, CA 90036
(323) 866-2200
(877) 866-2200
www.dgaplans.org