DGA-PRODUCER
HEALTH PLAN

summary of health plan benefits for non-U.S. participants

Updated: May 2025

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INTRODUCTION

Congratulations on qualifying for DGA–Producer Health Plan (Health Plan) coverage. **Even if you are covered under a national health plan, this summary of benefits for non-U.S. participants has important information for you.** The Health Plan offers a comprehensive set of medical, prescription, dental and vision benefits to qualifying non-U.S. participants and their eligible dependents. We hope you find this summary of benefits helpful, and we welcome your feedback.

This information contained is only a summary of the Health Plan's benefits available to you and your eligible dependents. We try to keep things as brief as possible, while still giving you a good understanding of your benefits as a non-U.S. resident. Where applicable, we refer you to the March 2025 Health Plan Summary Plan Description (SPD), which is the prevailing document for purposes of determining benefits. Nothing in this summary changes the benefits described in the SPD.

How You Are Notified of Health Plan Changes

Whenever we make changes to the Health Plan, we may notify you in the following ways:

- the *Spotlight on Benefits* newsletter, published quarterly; and
- the Health Plan Summary Plan Description Updates document, which lists all changes made to the Health Plan since the publication of the March 2025 Health Plan Summary Plan Description.

Both are available on our website at **www.dgaplans.org > Documents and Forms > Health** tab and the myPHP online benefits portal (registration required) at **www.dgaplans.org/myPHP > Documents and Forms > General Plans Documents**.

Services Received Outside the United States are Considered Non-Network

Unless obtained through a Blue Cross Blue Shield Global Core provider (see 5), all health claims for services received outside the United States are treated as non-network claims. Claims incurred inside the United States are covered based on whether the healthcare provider participates in the Health Plan's provider network.

How to Handle Foreign Languages and Currencies

When you submit a claim for processing (see the **Submitting Claims** section beginning on page 13 for more details on submitting a claim) and the claim is not in English, please submit the original claim along with an English translation to avoid further delay in the processing of the claim. Should you need further assistance, please see below for information on how to contact us.

Claims do not have to be converted to U.S. dollars. We will convert the amount of the claim based on the exchange rates as of the date of service.

CONTACT US

For questions about your benefits, please contact our Health Plan's Claims Department at:

DGA–Producer Health Plan
5055 Wilshire Blvd, Suite 600
Los Angeles, CA 90036

Telephone: (877) 866-2200, Ext. 401

MEDICAL COVERAGE

The Health Plan is a fee-for-service plan. This means that you can choose your own doctor. You are not limited to doctors within a specific network.

- If the service you need is not covered under your national health plan but is a covered service under the Health Plan, you can submit the claim to us.
- Even if the service is covered by your national health plan, you can submit the claim for covered services to the Health Plan if you see a doctor outside of your national health plan's network.

For example, if your national health plan does not cover dental benefits, you can submit those claims to Delta Dental, our dental benefit manager. Additionally, if you receive services such as a routine office visit or surgical procedure outside of your national health plan system, you can submit that claim to us for consideration and possible coverage.

FINDING DOCTORS OUTSIDE OF THE UNITED STATES

As a non-U.S. participant, you have access to BlueCross BlueShield Global Core. They can help you find a provider or hospital that will bill the Health Plan directly for services. For more information on the BlueCross BlueShield Global Core Program and the services they offer, call **(804) 673-1177** or visit **dgaplans.org/bcbsglobalcore**.

If Blue Cross Blue Shield Global Core cannot locate a Network provider in your area, any claims incurred with a provider that is outside of the United States are covered at the Health Plan's non-network rate (see chart below).

THE DGA CHOICE AND DGA PREMIER CHOICE PLANS

There are two levels of Earned Coverage under the Health Plan: the DGA Choice Plan and the DGA Premier Choice Plan.

- Earnings of **$39,820*** to **$129,149*** will qualify you for the DGA Choice Plan coverage.
- Earnings of at least **$*129,150*** will qualify you for the DGA Premier Choice Plan coverage.

* The minimum earnings threshold is periodically reviewed by the Board of Trustees. You should always contact the Health Plan or check the Plans' website for the current minimum earnings threshold. If 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.

WHAT YOU PAY

The Deductible

The Health Plan's deductible is $325 per individual, with a maximum of $975 per family, per calendar year. This means you will pay the first $325 on covered expenses before the Health Plan begins to pay on your claim each calendar year. Once each individual meets the $325 deductible or maximum of $975 per family in the calendar year, the Health Plan will begin to pay for covered services less your portion of co-insurance or co-payment on covered expenses. See the following **Co-Insurance** section.

Co-Insurance / Co-Payment

Co-Insurance is your share of the cost of covered services at a percentage of the Allowable Charge. Co-Payment is a fixed amount you pay on covered services.

After you meet the deductible, the Health Plan will cover benefits for covered services by non-network providers at the following percentages:

Plan	Non-Network Doctors
DGA Choice Plan	Health Plan Pays 60%
DGA Premier Choice Plan	Health Plan Pays 70%

Note: If you are in the United States and use a network provider, the Health Plan will pay 90% of the network contractual amount on covered expenses charged by the network provider.

Out-of-Pocket Limit

Each year, after you meet the deductible, the Health Plan limits the amount of co-insurance and other out-of-pocket expenses you and your eligible dependents pay on covered services in a calendar year. This limit is referred to as the "Out-of-Pocket" limit. Once you meet the out-of-pocket limit, the Health Plan will cover 100% of all covered services through the end of the year if it is not covered by your national health plan.

The following are the Health Plan's out-of-pocket limits:

Plan	Non-Network Doctors
DGA Choice Plan	$20,000
DGA Premier Choice Plan	$12,500

The out-of-pocket limit applies separately to each family member.

Covered and Non-Covered Services

The Health Plan's benefits are applicable when a medical procedure falls under **What's Covered Under Medical Benefits**, which starts on page 63 in the March 2025 Health Plan Summary Plan Description. Claims that are not covered under the Health Plan are listed in the **What's Not Covered Under Medical Benefits** section that starts on page 77 in the March 2025 Health Plan Summary Plan Description and/or its updates. Please refer to the Health Plan Summary Plan Description Updates available on the Documents and Forms page at **dgaplans.org**.

Not all services provided by a doctor are covered (cosmetic surgery, for example). You are responsible for 100% of the cost of non-covered services. The best way to determine if a treatment is covered is to call the Health Plan office.

Reasonable and Customary Charges (R&C)

When you visit a non-network doctor, the Health Plan will only consider charges up to the Reasonable and Customary (R&C) Allowed Amount for a covered service. You will be responsible for all charges over the R&C amount. Below is an example of how R&C works for someone who is covered under the Choice Plan after the deductible has been paid.

	Estimated Cost
Cost of Procedure A	$600
R&C for Procedure A	$300
Health Plan Pays	(60% of the R&C) $180
Total Cost to Health Plan	$180
Participant Pays	40% of the R&C
Co-Insurance	$120
Amount in Excess of R&C	$300
Total Cost to Participant	$420

The R&C amount is (1) 80% of the Fair Health rate or (2) 150% of the applicable Medicare reimbursement rate for a specified procedure when a Fair Health rate does not exist for the service provided; 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. For doctors outside of the United States, the R&C amount is based on 80% of the Fair Health rate for a specified procedure in the New York metropolitan area. The Health Plan will use the 150% of the applicable Medicare reimbursement rate when a Fair Health rate does not exist for the service provided. Even if you have reached your out-of-pocket limit, you will still be responsible for any cost over the R&C amount.

CONTACT INFORMATION

To find providers abroad, contact BlueCross BlueShield Global Core at (804) 673-1177. For additional questions regarding claims or coverage, contact the Health Plan at (877) 866-2200, Ext. 401 or visit dgaplans.org.

PRESCRIPTION COVERAGE

Prescription benefits are provided through CVS Caremark. When you begin coverage, CVS Caremark will send you an ID card that contains important information you will need when you submit a prescription drug claim to CVS Caremark for reimbursement (see the **What You Pay at a Non-Network Pharmacy** section below for more information). In addition, if you travel to the United States, you can use your ID card to fill prescriptions at a pharmacy.

PHARMACIES OUTSIDE OF THE UNITED STATES

All pharmacies outside of the United States are considered non-network pharmacies. You will not need your prescription ID card at these pharmacies. Instead, you will need to pay the full cost of the prescription and submit your prescription drug claim along with a completed CVS Caremark claim form to CVS Caremark for any form of reimbursement. See **Submitting a Prescription Claim** section on page 14 for instructions on submitting the claim to CVS Caremark.

WHAT YOU PAY AT A NON-NETWORK PHARMACY

When you purchase a covered prescription drug outside the United States, you must pay the full cost of the prescription at the time of purchase. You can then submit your claim to CVS Caremark for reimbursement. You will be reimbursed for the amount the Health Plan would have paid had the drug been purchased at a CVS Caremark-participating pharmacy in the United States.

See the **Submitting a Prescription Claim** section on page 14 for instructions on submitting a prescription drug claim to CVS Caremark.

WHAT'S COVERED

The Health Plan covers generic drugs, brand name drugs and certain lifestyle drugs.

To be eligible for coverage under the Health Plan's prescription drug benefit, a medication must be available in the United States and have received FDA approval. See pages 83-85 of the March 2025 Health Plan Summary Plan Description for more information.

To determine if a prescription drug has received FDA approval, you can browse the FDA's database of approved drug products at **www.accessdata.fda.gov/scripts/cder/drugsatfda/**. You may need both the drug's brand name (*e.g.,* Lipitor) and the chemical name (*e.g.,* atorvastatin calcium), as some medications are sold under a different brand name outside the United States. If you are unsure if the medication is FDA-approved, you can call the Health Plan at (877) 866-2200, Ext. 401.

Currently, lifestyle drugs include all non-GLP-1 weight loss drugs, erectile dysfunction drugs, proton pump inhibitors (like Nexium), non-sedating antihistamines, and sleep aides. GLP-1 drugs solely for weight loss are not covered by the Health Plan. There are special rules for coverage of proton pump inhibitors and sleep aides. See pages 86-87 of the March 2025 Health Plan Summary Plan Description for more information.

CONTACT INFORMATION

For more information regarding your prescription benefits or to discuss a claim, you can contact the Health Plan at (877) 866-2200, Ext. 401.

DENTAL COVERAGE

The Health Plan's dental benefits are provided through Delta Dental.

DENTISTS OUTSIDE OF THE UNITED STATES

All dentists outside of the United States are considered non-network dentists. For more information, see page 92 in the March 2025 Health Plan Summary Plan Description, which is also available on the Documents and Forms section at **dgaplans.org/forms/health**.

WHAT YOU PAY AT A NON-NETWORK DENTIST

When you visit a non-network dentist, you must pay your dentist at the time of service. Afterward, you can submit the claim to Delta Dental for reimbursement. Your claim will be reimbursed based on the deductibles, co-insurance and maximum benefit detailed below.

See the **Submitting a Dental Claim** section on page 14 for instructions on submitting a dental claim to Delta Dental.

Deductibles

For non-network dentists, the deductible is $50 per person per calendar year, with a maximum deductible of $100 per family each year. Non-network dental benefits are only payable once you satisfy this deductible.

Co-Insurance

Dental benefits are broken down into four categories: Category 1 (which includes exams and x-rays), Category 2 (which includes fillings and crowns), Category 3 (which includes bridges, dentures and oral surgery) and Orthodontics. The applicable co-insurance for dental benefits is as follows:

Type of Service	Non-Network Dentists
Category I	85% of Covered Expenses
Category II	60% of Covered Expenses
Category III	50% of Covered Expenses
Orthodontic Benefits	50% of Covered Expenses; coverage only available for dependent children under age 19; lifetime maximum of $1,500 per dependent child.

For non-network dentists, benefits are calculated based on Reasonable and Customary charges. See page 5 of this booklet for more information on Reasonable and Customary charges.

Maximum Benefit

There is a maximum dental benefit of $2,500 per person each year. This maximum does not apply to dependents under age 19.

CONTACT INFORMATION

For more information regarding your dental benefits or to discuss a claim, you can contact Delta Dental at (415) 972-8300. If you have any difficulty, please contact the Health Plan at (877) 866-2200, Ext. 401.

VISION COVERAGE

The Health Plan's vision benefits are provided through VSP Vision (VSP).

DOCTORS OUTSIDE OF THE UNITED STATES

All doctors outside of the United States are considered non-network doctors. See pages 98-99 of the March 2025 Health Plan Summary Plan Description for more information.

WHAT YOU PAY: NON-NETWORK

When you visit a non-network VSP provider, you must pay your provider at the time of service. Afterward, you can submit the claim to VSP Vision for reimbursement. Your claim will be reimbursed based on the payment schedules detailed below.

See the **Submitting a Vision Claim** section that begins on page 15 for instructions on submitting a vision claim to VSP.

Eye Exams

There is a $45 co-payment for eye exams.

The maximum benefit is one exam per calendar year.

Frames

There is a $70 allowance for eyeglass frames.

The maximum benefit is one set of frames every other calendar year.

The vision benefit covers a wide variety of frames, but not all frames are covered in full. You will be responsible for any costs that exceed the vision benefit's allowance.

Lenses

Following lists the allowances for eyeglass lenses or contact lenses.

- Up to $30 on single vision lenses;
- Up to $50 on lined bifocal lenses;
- Up to $65 on lined trifocal lenses;
- Up to $105 on elective contact lenses; and
- Up to $210 on medically necessary contact lenses.

The maximum benefit is one set of lenses per calendar year.

CONTACT INFORMATION

You can call VSP Vision at (916) 635-7373 for more information regarding your vision benefits or to discuss a claim. If you have any difficulty, please contact the Health Plan at (877) 866-2200, Ext. 401.

COVERING YOUR FAMILY

Your eligible family members under the Health Plan include:

- Your spouse;
- Your dependent children up to age 26; and
- Your disabled children age 26 and older, provided that the disability existed immediately prior to the maximum age and that your child was covered by the Health Plan immediately prior to turning age 26.

To enroll your family under your coverage, you must submit the following to the Health Plan office:

- **The Dependent Enrollment Form.** If this is your first time being covered, this form is included in your enrollment materials. Otherwise, it is available in the **Documents and Forms** section of **dgaplans.org**.
- **The Required Enrollment Documentation.** See the section below.

REQUIRED ENROLLMENT DOCUMENTATION

The following details what you need to send the Health Plan to enroll your family:

- **Your spouse.** If you have been married for one year or less, send us a copy of your certified marriage certificate.

  If you have been married for more than one year, we will need a copy of your certified marriage certificate and one of the following documents (not older than six months):

  - A copy of a joint household bill (*i.e.,* gas, water, or electric); or
  - A copy of a joint bank/credit account statement; or
  - A copy of your joint mortgage/lease; or
  - A copy of your joint insurance policy.

  The financial information can be redacted.

- **You and your spouse's natural children (up to age 26).** A copy of their certified birth certificate.
- **Your adopted children or children for whom you are their legal guardian (up to age 26).** Adoption or guardianship documents.
- **Your disabled children (age 26 and older).** Documentation proving total disability and that the child is dependent on you for support (contact the Heath Plan for a detailed description of the documentation required).

At the time you enroll, you may be required to submit additional information. Coverage for your family will begin when your coverage begins, or the date on which that person became your dependent, whichever is later. In other words, if you begin coverage on January 1 and get married on June 17, your spouse's coverage would begin on June 17, not January 1.

THE DEPENDENT PREMIUM

You are required to pay a dependent premium for Earned Coverage. The premium amount is based on the number of dependents you are covering.

When you enroll a dependent, the Health Plan will notify you if there is an additional premium due to cover your dependent and an invoice will be sent to you for the amount due.

The Health Plan's dependent premium is structured as follows:

Number of Dependents	Annual Premium
One Dependent	$780
Two or More Dependents	$1,200

The dependent premium can be paid annually or semi-annually based on your 12-month benefit period for earned coverage. It will not be prorated for periods of time shorter than your semi-annual benefit period.

PAYING PREMIUMS

If you are paying the dependent premium or self-paying for coverage, we offer several options (all of the forms mentioned below are available online at **dgaplans.org/openenrollment**):

- **Pay-by-Phone.** You can use E-Bill Express Pay-by-Phone by calling (877) 866-2200, Ext. 401 and follow the prompts. E-Bill Express only allows payments from United States banks/credit cards. In addition, if you do not have a Social Security number, please contact the Health Plan's office, and we can provide you the alternate Social Security number assigned to you.

- **Online Bill Pay.** You can use the Online Bill Pay at **dgaplans.org/payonline** to make payments via credit card or bank account debit.

- **Pension Deduction.** If you are receiving a monthly benefit from the Basic Pension Plan, you can have your self-pay premium deducted from your pension check, by completing a **Pension Deduction Authorization Form**, which can be found on **dgaplans.org/forms/pension**. Submit the form by the 15th of the month to have your payment processed the following month. This option is not available for dependent premium payment.

- **Wire Transfer.** You will need your Plan ID to make sure the payment can be properly identified.

If paying by check, make checks payable to **DGA–Producer Health Plan** and mail to **DGA–Producer Health Plan, 5055 Wilshire Blvd., Ste. 600, Los Angeles, CA 90036**.

The Importance of Paying Premiums On Time

Health Plan premium payments are due on the first day of the month. You then have a 30-day grace period before your coverage is cancelled.

During your premium payment grace period, you and your dependents will still be eligible for benefits, but our records will not reflect coverage until payment of your premium is received. Any claim received prior to your premium being paid will be denied. If you subsequently remit payment prior to the end of your grace period, you can re-submit the denied claim.

SUBMITTING CLAIMS

If your claim is in a non-English language, please submit the original claim along with an English translation. Your claim does not have to be converted to U.S. dollars. It will be converted based on the exchange rates in effect as of the date of service.

SUBMITTING A HEALTH CLAIM

To submit a health claim for services received outside the U.S., follow the three steps below:

1. Download the **Claim Form – Medical – Services Received Outside the U.S.**, which can be found on **dgaplans.org/forms/health**.

   This is the BlueCross BlueShield Global Core International Claim Form. You should submit the completed form along with any itemized bill you might have.

2. Be sure your completed claim (which includes a completed BlueCross BlueShield Global Core International Claim Form with an itemized bill) includes all the information below.

   - Participant's Name and Plan ID Number (as it appears on your Health Plan ID Card)
   - The Health Plan's Group Number (as it appears on your Health Plan ID Card)
   - Provider's Name, Address and Federal Tax ID Number
   - Patient's Name and Date of Birth
   - Amount Paid
   - A Description of Services and Diagnosis (provided by your doctor)

   If you do not provide all of the information above, your claim could be delayed.

3. Submit your claim to BlueCross BlueShield Global Core using the information below. It is recommended that you submit your claim by email, mobile app or online to have proof of your claim submission.

Submission Types	
Email	claims@bcbsglobalcore.com
Mobile App	Download for Android (https://play.google.com/store/apps/details?id=com.hthworldwide.BlueCard) Download for iOS (https://itunes.apple.com/us/app/blue-cross-blue-shield-global-core/id775275902?mt=8)
Online	www.bcbsglobalcore.com
Mail	**DO NOT submit claims to the Health Plan Office** Mail your claim directly to BlueCross BlueShield Global Core Claims at the address below: **Service Center** P.O. Box 2048 Southeastern, PA 19399

SUBMITTING A PRESCRIPTION CLAIM

To be eligible for coverage under the Health Plan's prescription drug benefit, a medication must be available in the United States and have received FDA approval. If you are unsure if the medication is FDA-approved, you can call the Health Plan at (877) 866-2200, Ext. 401.

Fill out the **Claim Form - Prescription**, which can be found on **dgaplans.org/forms/health**.

- In the *Group Number* field, write in "**DGA-PPHP**."
- In the *Member ID* field, write in the Member ID that appears on your CVS Caremark prescription card.

Be sure to include prescription receipts with your CVS Caremark claim form.

Submit your claim to CVS Caremark using the information below. It is recommended to fax your claims in order to have proof of your claim submission. You must complete one CVS Caremark claim form for each fax submission and should not combine more than one family member per claim form.

Submission Types	
Mail	**DO NOT submit claims to the Health Plan Office** Mail your claim directly to CVS Caremark at the address below: **CVS Caremark Claims Department** PO Box 52136 Phoenix, AZ 85072-2136

SUBMITTING A DENTAL CLAIM

All non-U.S. dental claims should be filed with Delta Dental, the Health Plan's dental benefit manager. Fill out the **Claim Form - Dental**, which can be found on **dgaplans.org/forms/health**. Complete sections 1-15 of the form.

- For Section 9, *Employer (Company) Name*, write in "**DGA-PPHP**."
- For Section 10, *Group Number*, write in "**0480**."

If you do not have a U.S. Social Security number, you can either call the Health Plan Office for the alternate Social Security number assigned to you for identification purposes or enter your "Enrollee Number" which appears on your Delta Dental coverage card.

Attach a copy of the dentist's statement of treatment to the claim form. The statement of treatment should include the dentist's name, phone number, a description of each service the dentist performed, and the amounts billed and paid for each service.

Mail the completed form and statement to:

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330

SUBMITTING A VISION CLAIM

All non-U.S. vision claims should be filed with VSP Vision, the Health Plan's vision benefit manager. Fill out the **Claim Form - Vision**, which can be found on **dgaplans.org/forms/health**.

Submit your claim to VSP Vision using the information below. It is recommended to email or fax your claims in order to have proof of your claim submission.

Submission Types	
Email	rebekah.mcgaughey@vsp.com
Fax	(916) 858-5588
Mail	**DO NOT submit claims to the Health Plan Office** Mail your claim directly to VSP Vision at the address below: **VSP** ATTN: Claim Services P.O. Box 495918 Cincinnati, OH 45249-5918

CONTACT INFORMATION FOR NON-U.S. PARTICIPANTS

- For medical claims, call BlueCross BlueShield Global Core at (804) 673-1177.
- For dental claims, call Delta Dental at (415) 972-8300.
- For prescription claims, call the Health Plan at (877) 866-2200, Ext. 401.
- For vision claims, call VSP at (916) 635-7373.

If you experience any problems contacting BlueCross BlueShield Global Core, Delta Dental or VSP, please call the Health Plan at **(877) 866-2200, Ext. 401** for further assistance.