DGA-PRODUCER
HEALTH PLAN

health plan benefits for non-U.S. participants

Updated: March 2, 2020

TABLE OF CONTENTS

INTRODUCTION

Congratulations on qualifying for DGA–Producer Health Plan coverage. **Even if you are covered under a national health plan, this booklet has important information for you.** The Health Plan offers a comprehensive set of medical, prescription, dental, and vision benefits to qualifying DGA members and their families. We hope you find this booklet helpful and we welcome your feedback.

This booklet is only a summary of the benefits available to you. We try to keep things as brief as possible, while still giving you a good understanding of your benefits as a foreign resident. Where applicable, we refer you to the March 2020 Health Plan Summary Plan Description, which have much more detailed descriptions of the Health Plan's rules and benefits.

Health Plan Updates

Whenever we make changes to the Health Plan, we notify you through the Health Plan's quarterly newsletter, *Spotlight on Benefits*. In addition, we maintain a document (the Health Plan Booklet Updates) with all of the changes to the March 2020 Health Plan Summary Plan Description since it was published. An up-to-date version of the Health Plan Booklet Updates will always be available on the **Documents and Forms** section of **dgaplans.org**.

Claims Incurred Outside the United States

All health claims incurred 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.

Foreign Languages and Currencies

When you submit a claim for processing (see the **Submitting Claims** section beginning on page 12 for more details on submitting a claim), if the claim is in a non-English language, please submit the original claim along with an English translation. If you need 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

If you ever have any questions about your benefits, you can contact our Health Plan's Claims Department at:

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

Telephone: (323) 866-2233

Our staff has extensive experience dealing with foreign claims and will be able to assist you.

MEDICAL COVERAGE

The DGA–Producer 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 covered under our 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 us 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 reimbursement.

FINDING DOCTORS OUTSIDE OF THE UNITED STATES

As a foreign 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**.

All doctors outside of the United States are covered at the Plan's non-network rate (see chart below).

THE DGA CHOICE AND DGA PREMIER CHOICE PLANS

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

- Earnings of **$35,875** to **$115,999** will qualify you for the DGA Choice Plan coverage.
- Earnings of at least **$116,000** will qualify you for the DGA Premier Choice Plan coverage.

WHAT YOU PAY

The Deductible

The Health Plan's deductible is $325 per individual, with a maximum of $975 per family, per calendar year. So, you will pay the first $325 in covered medical costs for each member of your family each year, up to $975. Then, co-insurance will apply.

Co-Insurance

After you meet the deductible, we 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 contract amount charged by the provider.

Out-of-Pocket Limit

Each year, after you meet the deductible, we limit the amount you pay for covered medical costs. This limit is referred to as the out-of-pocket limit. Once you meet the out-of-pocket limit, we 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	$8,900
DGA Premier Choice Plan	$3,550

There is a separate out-of-pocket limit for 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 54 in the March 2020 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 63 in the March 2020 Health Plan Summary Plan Description. For updates to the March 2020 Health Plan Summary Plan Description, please refer to the Health Plan Booklet Updates available on the Documents and Forms section of **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 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) 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.

	Non-Network Doctor
Cost of Procedure A	$600
R&C for Procedure A	$300
Health Plan Pays Co-Insurance	60% of the R&C $180
Total cost to Health Plan	$180
Participant Pays Co-Insurance Amount in excess of R&C	40% of the R&C $120 $300
Total cost to Participant	$420

The R&C amount is calculated based on the average charge for a medical service by a percentage of doctors in a given area. For doctors outside of the United States, the R&C amount is based on provider rates in the New York metropolitan area. 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 **(323) 866-2233** or visit **dgaplans.org**.

PRESCRIPTION COVERAGE

Prescription benefits are provided through Express Scripts. When you begin coverage, Express Scripts will send you an ID card that contains important information that you will need when you submit a prescription drug claim to our office 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 pay for the prescription and submit the claim for reimbursement to Express Scripts. See **Submitting a Prescription Claim** section on page 13 for instructions on submitting the claim to Express Scripts.

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 Express Scripts for reimbursement. You will be reimbursed for the amount the Plan would have paid had the drug been purchased at an Express Scripts-participating pharmacy in the United States.

See the **Submitting a Prescription Claim** section on page 13 for instructions of submitting a prescription drug claim to Express Scripts.

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 67-68 of the March 2020 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 (323) 866-2233.

Currently, lifestyle drugs include erectile dysfunction drugs, proton pump inhibitors (like Nexium), non-sedating antihistamines, and sleep aides. There are special rules for coverage of proton pump inhibitors and sleep aides. See pages 70-71 of the March 2020 Health Plan Summary Plan Description for more information.

CONTACT INFORMATION

You can call the Health Plan at **(323) 866-2233** for more information regarding your prescription benefits or to discuss a claim.

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 75 in the March 2020 Health Plan Summary Plan Description. The March 2020 Health Plan Summary Plan Description, which is mailed to all participants, is also available on the Documents and Forms section of **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 13 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%
Category II	60%
Category III	50%
Orthodontic Benefits	50%

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.

Orthodontic Benefits are only available up to age 19. The lifetime maximum for all orthodontic treatment is $1,500 per dependent child whether or not there has been an interruption in dental coverage.

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

You can call Delta Dental at **(415) 972-8300** for more information regarding your dental benefits or to discuss a claim. If you have any difficulty, please contact the Health Plan at **(323) 866-2233**.

VISION COVERAGE

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

DOCTORS OUTSIDE OF THE UNITED STATES

All doctors outside of the United States are considered non-network doctors. See pages 77-79 of the March 2020 Health Plan Summary Plan Description for more information.

WHAT YOU PAY: NON-NETWORK

When you visit a non-network vision services provider, you must pay your provider at the time of service. Afterward, you can submit the claim to us 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 13 for instructions on submitting a vision claim to VSP.

Eye Exams

There is a $30 co-payment for eye exams. You can receive a maximum reimbursement of $45.

The maximum benefit is one exam per year.

Frames

There is a $220 allowance for eyeglass frames ($240 for featured frame brands). You can receive a maximum reimbursement of $70.

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

There is a $200 allowance for eyeglass lenses or contact lenses.

You can receive a maximum reimbursement of:

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

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

CONTACT INFORMATION

You can call VSP 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 **(323) 866-2233**.

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 on 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 us 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 (no older than six months):

  - A copy of a joint household bill, such as 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 us 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 premium for dependent coverage. The premium amount is based on the amount of dependents that you are covering.

When you enroll a dependent, we will notify you if there is an additional premium due on behalf of your dependent and we will send you an invoice 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 earned coverage benefit period. 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 (323) 866-2200 and following 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 Office, and we can provide you the alternate Social Security number we assigned 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.* 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.

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 or without an itemized bill) includes all the information below.

   - Participant's Name and Health 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: **BCBS Global Core Claims** 933 First Avenue King of Prussia, PA 19406

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 (323) 866-2233.

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 Express Scripts prescription card.

Be sure to include prescription receipts with your claim form.

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

Submission Types	
FAX	(608) 741-5475
Mail	**DO NOT submit claims to the Health Plan Office** Mail your claim directly to Express Scripts at the address below: **Express Scripts, Inc.** ATTN: Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872

SUBMITTING A DENTAL CLAIM

All foreign 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 our office for the alternate social security number we 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 foreign vision claims should be filed with Vision Service Plan, 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 Vision Service Plan 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	misty.bach@vsp.com
FAX	(916) 858-5588
Mail	**DO NOT submit claims to the Health Plan Office** Mail your claim directly to Vision Service Plan at the address below: **Vision Service Plan** ATTN: Claim Services P.O. Box 385018 Birmingham, AL 35238-5018

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 (323) 866-2233.
- 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 **(323) 866-2233** for further assistance.

NONDISCRIMINATION NOTICE

The Directors Guild of America - Producer Health Plan (the "Plan") does not discriminate on the basis of race, color, national origin, sex, age, or disability. The 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 Plan's Civil Rights Coordinator at:

Mail: Directors Guild of America—Producer Pension and Health Plans
5055 Wilshire Blvd, Suite 600
Los Angeles, CA 90036
Attn: Civil Rights Coordinator

Phone: (323) 866-2233

Fax: (323) 866-2348

If you believe the 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 Plan's Civil Rights Coordinator as soon as possible at the address listed above. If you need help filing a claim, please contact the Plan's 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., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/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. 1-877-866-2200 번으로 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.

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-866-2200.

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 به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-866-2200 تماس بگیرید.