

DGA–Producer Health Plan: Bronze Plan

Summary of Benefits and Coverage: What this [Plan](#) Covers & What You Pay For Covered Services

Coverage Period: January 1, 2021 – December 31, 2021

Coverage for: Individual, Individual + 1, Family | [Plan](#) Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to at dgaplans.org or call 1-877-866-2200. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at dgaplans.org or request a copy by calling 1-877-866-2200 or emailing your request to eligibility@dgaplans.org.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$750 per person \$2,250 per family</p>	<p>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meet the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Certain preventive care services are covered at 100% with no deductible or copayment if they are rendered by a network provider.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>There are no other specific deductibles.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For network providers \$8,550 per person \$17,100 per family For non-network providers \$12,500 per person There is an annual all-inclusive network out-of-pocket limit of \$8,550 per person / \$17,100 per family. This limit sets a maximum on the amount you pay out-of-pocket in a calendar year on deductibles, copayments and coinsurance.</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.dgaplans.org.]

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What is not included in the out-of-pocket limit?	Premiums , non-covered expenses, deductibles , emergency room care copayments , and balance billing for charges in excess of usual, customary, and reasonable charges. The annual all-inclusive network out-of-pocket limit excludes all of the above except for deductibles and copayments .	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. For a list of network providers , see dgaplans.org or call (800) 810-2583.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of- network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of- network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan .

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All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. When using an out-of-network provider, you may also be responsible for any amount that exceeds the plan's usual, customary & reasonable charges, in addition to the 50% coinsurance.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information	
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	50% coinsurance	—————none—————	
	Specialist visit	30% coinsurance	50% coinsurance		
	Preventive care ¹ / screening /immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	—————none—————	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at dgaplans.org	Generic drugs	Not Covered	Not Covered	—————none—————	
	Preferred brand drugs	Not Covered	Not Covered		
	Non-preferred brand drugs	Not Covered	Not Covered		
	Specialty drugs	Not Covered	Not Covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Non- network ambulatory surgical center is limited to an allowed amount of \$1,500.	
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Does not include hospitalization fees.	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	\$50 copayment applies and is only waived if admitted to the hospital.	
	Emergency medical transportation	30% coinsurance	30% coinsurance		—————none—————
	Urgent care	30% coinsurance	50% coinsurance		

¹ Includes [preventive care](#) services as recommended by the government. Contact the Health Plan office for a complete list of [Preventive Care](#) Services.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	\$500 copayment applies per admission to a non- network hospital. This copayment is waived for participants who live or work more than 30 miles from a network hospital. All inpatient admission will require preauthorization from Anthem Blue Cross.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	All intensive out-patient and partial hospitalization care will require preauthorization from Anthem Blue Cross.
	Inpatient services	30% coinsurance	50% coinsurance	All inpatient and residential admissions will require preauthorization from Anthem Blue Cross.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Maternity care is not provided to dependent children, unless the dependent child has complications of pregnancy .
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care ⁺	30% coinsurance	50% coinsurance	⁺ Rest cures, custodial care, educational therapy, play therapy, or treatment of learning disabilities are not covered. ⁺ Speech therapy and Occupational Therapy expenses will not be 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. Coverage is limited to 860 hours/year for home nursing care. Coverage is limited to the allowed amount . —————none—————
	Rehabilitation services	30% coinsurance	50% coinsurance	
	Habilitation services ⁺	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	
	Durable medical equipment	30% coinsurance	50% coinsurance	
	Hospice services	30% coinsurance	50% coinsurance	

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children’s eye exam	Not Covered	Not Covered	—————none—————
	Children’s glasses	Not Covered	Not Covered	
	Children’s dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Charges in Excess of [Usual, Customary and Reasonable](#) Charges
- Cosmetic Surgery, see [Plan](#) Booklet for details
- Custodial Care
- Dental Care (Adult)
- Expenses incurred not due to sickness or injury
- Infertility Treatment
- Inpatient Private-Duty Nursing
- Long-Term Care
- [Prescription Drugs](#)
- Routine Eye Care (Adult)
- Routine Foot Care, except special shoes/inserts relating to diabetes
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your [plan](#) document.)

- Acupuncture
- Bariatric Surgery (with [Preauthorization](#))
- Chiropractic Care
- [Emergency Services](#)
- Hearing Aids
- Non-[emergency services](#) when traveling outside the U.S. (e.g., doctor’s visit)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those federal agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

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Your [Grievance and Appeals Rights](#): There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

Directors Guild of America-Producer Health Plan at 1-877-866-2200, Monday to Friday 8:30 a.m. to 5:00 p.m., Pacific Standard Time or www.dgaplans.org.

Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or <http://www.healthhelp.ca.gov>.

Does this plan provide [Minimum Essential Coverage](#)? Yes

If your [plan](#) doesn’t meet the [Minimum Essential Coverage](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Does this plan meet the [Minimum Value Standards](#)? Yes

If your [plan](#) doesn’t meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-866-2200.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-866-2200.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-866-2200.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-866-2200.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-[network](#) pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist](#) [[cost sharing](#)] \$0
- Hospital (facility) [[cost sharing](#)] 30%
- Other [[cost sharing](#)] 30%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700.00
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$750.00
Copayments	\$0.00
Coinsurance	\$3,430.00
What isn't covered	
Limits or exclusions	\$70.00
The total Peg would pay is	\$4,250.00

Managing Joe's type 2 Diabetes

(a year of routine in-[network](#) care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist](#) [[cost sharing](#)] \$0
- Hospital (facility) [[cost sharing](#)] 30%
- Other [[cost sharing](#)] 30%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600.00
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$750.00
Copayments	\$0.00
Coinsurance	\$50.00
What isn't covered	
Limits or exclusions	\$4,470.00
The total Joe would pay is	\$5,270.00

Mia's Simple Fracture

(in-[network](#) emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist](#) [[cost sharing](#)] \$0
- Hospital (facility) [[cost sharing](#)] 30%
- Other [[cost sharing](#)] 30%

This EXAMPLE event includes services like:

- [Emergency room services](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)

Total Example Cost	\$2,800.00
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$750.00
Copayments	\$50.00
Coinsurance	\$600.00
What isn't covered	
Limits or exclusions	\$10.00
The total Mia would pay is	\$1,410.00

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.