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 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:
What is the overall deductible?	**$325** per person **$975** per family	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.
Are there services covered before you meet your deductible?	Yes. Certain preventive care services are covered at 100% with no deductible or copayment if they are rendered by a network provider.	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/.
Are there other deductibles for specific services?	Yes. For non-network dental -- **$50** per person / **$100** per family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers **$1,000** per person For non-network providers **$3,550** per person There is an 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.	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.

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

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, non-covered expenses, deductibles, prescription drugs, emergency room care copayments, balance billing for charges in excess of usual, customary and reasonable charges, dental benefits, vision benefits, and co-payments incurred at a UCLA/Entertainment Industry Medical Group facility. The all-inclusive network out-of-pocket limit excludes all of the above except for deductibles, copayments and coinsurance.	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. However, a referral is required when a specialist is referred by a physician from a UCLA/Entertainment Industry Medical Group.	You can see the specialist you choose without permission from this plan.

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

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 30% coinsurance.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance $10/visit at an EIMG facility	30% coinsurance	——————none——————
	Specialist visit	10% coinsurance $10/visit at an EIMG facility	30% coinsurance	
	Preventive care[1] screening/ immunization	No Charge	30% 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)	10% coinsurance	30% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at dgaplans.org	Generic drugs	Mail order: $25 / prescription Pharmacy: $10 / prescription	The network copayment plus all charges over the amount a network pharmacy would have charged	Mail order/CVS Caremark Maintenance Choice is a 90-day supply Pharmacy is a 30-day supply Contraceptives covered at 100%
	Preferred brand drugs	Mail order: $60 / prescription Pharmacy: $24 / prescription	The network copayment plus all charges over the amount a network pharmacy would have charged	Mail order/CVS Caremark Maintenance Choice is a 90-day supply Pharmacy is a 30-day supply
	Non-preferred brand drugs	Mail order: $60 / prescription Pharmacy: $24 / prescription	The network copayment plus all charges over the amount a network pharmacy would have charged	Subject to step therapy, which requires participants to try a preferred drug before electing a non-preferred drug. Some non-preferred drugs may not be covered.

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

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at dgaplans.org	Specialty drugs	With PrudentRx Enrollment: $0 Without PrudentRx Enrollment: 30% coinsurance	The network coinsurance plus all charges over the amount a network pharmacy would have charged	Participant pays 100% of cost if not preauthorized by CVS Caremark. Eligible Lifestyle drugs are covered at greater of $40 or 50% of the cost of medication at a retail pharmacy and greater of $60 or 50% of the cost of medication for Mail Order.
If you have outpatient surgery	Facility fee (*e.g.,* ambulatory surgery center)	10% coinsurance	30% coinsurance	Non-network ambulatory surgical center is limited to $1,500 allowable.
	Physician/surgeon fees	10% coinsurance $100 copayment through EIMG referral	30% coinsurance	Does not include hospitalization fees.
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	$50 copayment applies and is only waived if admitted to the hospital.
	Emergency medical transportation	10% coinsurance	10% coinsurance	——————none——————
	Urgent care	10% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (*e.g.,* hospital room)	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	All intensive out-patient and partial hospitalization care will require preauthorization from Anthem Blue Cross.
	Inpatient services	10% coinsurance	30% coinsurance	All inpatient and residential admissions will require preauthorization from Anthem Blue Cross.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Maternity care is not provided to dependent children, unless the dependent child has complications of pregnancy.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

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

If you need help recovering or have other special health needs	Home health care†	10% coinsurance	30% 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.
	Rehabilitation services	10% coinsurance	30% coinsurance	
	Habilitation services‡	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage is limited to 860 hours/year for home nursing care.
	Durable medical equipment	10% coinsurance	30% coinsurance	Coverage is limited to the allowed amount.
	Hospice services	10% coinsurance	30% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	$30 copayment	$30 copayment	Coverage is limited to one exam per year. Out-of-network reimbursement limited based on payment schedule.
	Children's glasses	$30 copayment	$30 copayment	Coverage is limited to one pair of eyeglass lenses per year and frames once every other year. Out-of-network reimbursement limited based on payment schedule.
	Children's dental check-up	No charge	15% coinsurance	Coverage is limited to one check-up/150 consecutive days.

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
- Expenses incurred not due to sickness or injury
- Infertility Treatment
- Inpatient Private-Duty Nursing
- Long-Term Care
- 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
- Dental Care (Adult)
- Emergency Services
- Hearing Aids
- Non-emergency services when traveling outside the U.S. *(e.g.,* doctor's visit)
- Routine Eye Care (Adult)

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.

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.

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

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, kwiijigo holne' 1-877-866-2200.

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

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	$325
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$325.00
Copayments	$10.00
Coinsurance	$1,000.00
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$1,395.00**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$325
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$325.00
Copayments	$770.00
Coinsurance	$90.00
What isn't covered	
Limits or exclusions	$230.00
The total Joe would pay is	**$1,415.00**

Mia's Simple Fracture

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

The plan's overall deductible	$325
Specialist *[cost sharing]*	$0
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800.00**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$325.00
Copayments	$60.00
Coinsurance	$240.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$625.00**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.