

# DGA–Producer Health Plan: Silver Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: September 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 [dgaplans.org](https://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](https://dgaplans.org) or request a copy by calling 1-877-866-2200 or emailing your request to [eligibility@dgaplans.org](mailto:eligibility@dgaplans.org).

Important Questions	Answers	Why This Matters:
<p><b>What is the overall deductible?</b></p>	<p>\$325 per person \$975 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><b>Are there services covered before you meet your deductible?</b></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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other deductibles for specific services?</b></p>	<p>No.</p>	<p>There are no other specific deductibles.</p>
<p><b>What is the out-of-pocket limit for this plan?</b></p>	<p>For network providers \$1,000 per person. For non-network providers \$8,900 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>
<p><b>What is not included in the out-of-pocket limit?</b></p>	<p>Premiums, non-covered expenses, deductibles, prescription drugs, emergency room care copayments, balance billing for charges in excess of usual, customary and reasonable charges, and charges</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

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	incurred at a UCLA/Entertainment Industry Medical Group facility. The all-inclusive <a href="#">network out-of-pocket limit</a> excludes all of the above except for <a href="#">deductibles</a> , <a href="#">copayments</a> and <a href="#">coinsurance</a> .	
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of <a href="#">network providers</a> , see <a href="#">dgaplans.org</a> or call (800) 810-2583.	This plan uses a <a href="#">provider network</a> . You will pay less if you use a provider in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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 <a href="#">specialist</a> you choose without permission from this plan.

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

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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 40% 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a> \$10/visit at an EIMG facility	40% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a> \$10/visit at an EIMG facility	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care</a> <sup>1</sup> / <a href="#">screening</a> / immunization	No Cost	40% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">dgaplans.org</a>	Generic drugs	Mail order: \$25 / prescription Pharmacy: \$10 / prescription	The <a href="#">network copayment</a> plus all charges over the amount a <a href="#">network</a> 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 <a href="#">network copayment</a> plus all charges over the amount a <a href="#">network</a> 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 <a href="#">network copayment</a> plus all charges over the amount a <a href="#">network</a> 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.

<sup>1</sup> 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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://dgaplans.org">dgaplans.org</a>	<a href="#">Specialty drugs</a>	With PrudentRx Enrollment: \$0 Without PrudentRx Enrollment: 30% <a href="#">coinsurance</a>	The <a href="#">network coinsurance</a> plus all charges over the amount a <a href="#">network</a> pharmacy would have charged	Participant pays 100% of cost if not <a href="#">preauthorized</a> by CVS Caremark. Eligible Lifestyle drugs are covered at greater of \$60 or 50% of the cost of medication.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Non-network ambulatory surgical center is limited to the <a href="#">allowed amount</a> of \$1,500.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> \$100/ <a href="#">copayment</a> through EIMG referral	40% <a href="#">coinsurance</a>	Does not include hospitalization fees.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	\$50 <a href="#">copayment</a> applies and is only waived if admitted to the hospital.  —————none—————
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$500 <a href="#">copayment</a> applies per admission to a non- <a href="#">network</a> hospital. This <a href="#">copayment</a> is waived for participants who live or work more than 30 miles from a <a href="#">network</a> hospital.  All inpatient admission will require <a href="#">preauthorization</a> from Anthem Blue Cross.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	All intensive out-patient and partial <a href="#">hospitalization</a> care will require <a href="#">preauthorization</a> from Anthem Blue Cross.
	Inpatient services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	All inpatient and residential admissions will require <a href="#">preauthorization</a> from Anthem Blue Cross.
If you are pregnant	Office visits	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maternity care is not provided to dependent children, unless the dependent child has <a href="#">complications of pregnancy</a> .
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<p>* Rest cures, custodial care, educational therapy, play therapy, or treatment of learning disabilities are not covered.</p> <p>* 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.</p> <p>Coverage is limited to 860 hours/year for home nursing care.</p> <p>Coverage is limited to the <a href="#">allowed amount</a>.</p> <p>—————none—————</p>
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
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	

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## 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
- Long-Term Care
- Routine Foot Care, except special shoes/inserts relating to diabetes

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

- Acupuncture
- Bariatric Surgery (w/[Preauthorization](#))
- Chiropractic Care
- [Emergency Services](#)
- Dental Care (Adult)
- Hearing Aids
- Non-[emergency services](#) when traveling outside the U.S.
- Inpatient Private-Duty Nursing (except custodial care)
- Routine Eye Care (Adult)
- Weight Loss Programs

**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](http://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](http://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](http://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](http://www.dgaplans.org)

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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>.

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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, kwijjigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$325
■ <a href="#">Specialist [cost sharing]</a>	\$0
■ Hospital (facility) <a href="#">[cost sharing]</a>	10%
■ Other <a href="#">[cost sharing]</a>	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*)

<b>Total Example Cost</b>	<b>\$7,540.00</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$325.00
<a href="#">Copayments</a>	\$0.00
<a href="#">Coinsurance</a>	\$721.50
What isn't covered	
Limits or exclusions	\$0.00
<b>The total Peg would pay is</b>	<b>\$1,046.50</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$325
■ <a href="#">Specialist [cost sharing]</a>	\$0
■ Hospital (facility) <a href="#">[cost sharing]</a>	10%
■ Other <a href="#">[cost sharing]</a>	10%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,400.00</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$325.00
<a href="#">Copayments</a>	\$0.00
<a href="#">Coinsurance</a>	\$507.50
What isn't covered	
Limits or exclusions	\$0.00
<b>The total Joe would pay is</b>	<b>\$832.50</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$325
■ <a href="#">Specialist [cost sharing]</a>	\$0
■ Hospital (facility) <a href="#">[cost sharing]</a>	10%
■ Other <a href="#">[cost sharing]</a>	10%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$750.00</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$325.00
<a href="#">Copayments</a>	\$50.00
<a href="#">Coinsurance</a>	\$37.50
What isn't covered	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$412.50</b>

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