



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-877-866-2200 to request a copy or email your request to [eligibility@dgaplans.org](mailto:eligibility@dgaplans.org).

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$325</b> per person <b>\$975</b> per family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Certain <a href="#">preventive care</a> services are covered at 100% with no <a href="#">deductible</a> or <a href="#">copayment</a> if rendered by a <a href="#">network provider</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. Non-network dental: <b>\$50</b> per person / <b>\$100</b> per family. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this plan begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : <b>\$1,000</b> per person. Non- <a href="#">network providers</a> : <b>\$3,550</b> per person.  There is an all-inclusive <a href="#">network out-of-pocket limit</a> : <b>\$9,450</b> per person / <b>\$18,900</b> per family. This limit sets a maximum on the amount you pay out-of-pocket in a calendar year on <a href="#">deductibles</a> , <a href="#">copayments</a> , and <a href="#">coinsurance</a> .	The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.

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

## DGA–Producer Health Plan: Premier Choice/Premier Gold Plan

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

Coverage Period: January 1, 2024 -December 31, 2024

Coverage for: Individual, Individual + 1, Family | Plan Type: PPO

Important Questions	Answers	Why This Matters:
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , non-covered expenses, <u>deductibles</u> , <u>balance-billing</u> charges in excess of <u>usual, customary and reasonable</u> charges, specific copayments (including <u>prescription drugs</u> , <u>emergency room care</u> , and UCLA/Entertainment Industry Medical Group services), dental and vision benefits, and health care this <u>plan</u> doesn't cover. The annual all-inclusive <u>network out-of-pocket limit</u> excludes all of the above except for <u>deductibles</u> , <u>copayments</u> and <u>coinsurance</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of <u>network providers</u> , see <a href="http://dgaplans.org">dgaplans.org</a> or call (800) 810-2583.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No, except for specialists at UCLA/Entertainment Industry Medical Group, where a referral is required.	Generally, you can see the <u>specialist</u> you choose without a <u>referral</u> . However, for UCLA/Entertainment Industry Medical Group physicians, this <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services, but only if you have a <u>referral</u> before you see the <u>specialist</u> .

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

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All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most. Coinsurance amounts based on covered expenses.)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u> \$10/visit at an EIMG facility	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u> \$10/visit at an EIMG facility	30% <u>coinsurance</u>	
	<u>Preventive care</u> <sup>1</sup> <u>/screening/</u> immunization	No Charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. Not all services are considered preventive during a preventive screening and coinsurance may be applicable.
	<sup>1</sup> Includes <u>preventive care</u> services as recommended by the government. For a complete list of <u>Preventive Care</u> Services, visit <a href="https://www.uspreventiveservicestaskforce.org">https://www.uspreventiveservicestaskforce.org</a> and look for "A" and "B" recommendations.			
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="https://www.dgaplans.org/the-dga-producer-health-plan/Prescription-benefits-overview/">https://www.dgaplans.org/the-dga-producer-health-plan/Prescription-benefits-overview/</a>	Generic drugs	Mail order: \$25/prescription Pharmacy:\$10/prescription	<u>Network copayment</u> plus all charges exceeding <u>network</u> pharmacy rates.	Retail Pharmacy: 30-day supply. Mail order/CVS Caremark Maintenance Choice: 90-day supply, mandatory after two 30-day retail fills. Contraceptives: 100% coverage.
	Preferred brand drugs	Mail order: \$60/prescription Pharmacy: \$24/prescription	<u>Network copayment</u> plus all charges exceeding <u>network</u> pharmacy rates.	Retail Pharmacy: 30-day supply. Mail order/CVS Caremark Maintenance Choice: 90-day supply, mandatory after two 30-day retail pharmacy fills.
	Non-preferred brand drugs	Mail order: \$60/prescription Pharmacy: \$24/prescription	<u>Network copayment</u> plus all charges exceeding <u>network</u> pharmacy rates.	Subject to step therapy: must try preferred drug before electing a non-preferred drug. Some non-preferred drugs not covered.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most. Coinsurance amounts based on covered expenses.)	
	<a href="#">Specialty drugs</a>	With PrudentRx Enrollment: \$0. Without PrudentRx Enrollment: 30% <a href="#">coinsurance</a> .	<a href="#">Network coinsurance</a> plus all charges exceeding <a href="#">network</a> pharmacy rates.	Participant pays 100% if not <a href="#">preauthorized</a> by CVS Caremark. Eligible Lifestyle drugs: covered at greater of \$40 or 50% (retail); greater of \$60 or 50% (Mail Order/CVS retail).Not all specialty drugs are eligible for CVS Caremark PrudentRx.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> , including through EIMG <a href="#">referral</a>	30% <a href="#">coinsurance</a>	Non- <a href="#">network</a> 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> w/ EIMG <a href="#">referral</a>	30% <a href="#">coinsurance</a>	Does not include <a href="#">hospitalization</a> fees.
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	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>	30% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$500 <a href="#">copayment</a> per non- <a href="#">network</a> hospital admission (waived for participants who live or work more than 30 miles from a <a href="#">network</a> hospital). All inpatient admission requires <a href="#">preauthorization</a> from Anthem Blue Cross.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None

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		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most. Coinsurance amounts based on covered expenses.)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Outpatient individual therapy office visits covered. No coverage for family, marriage, and relationship counseling. After 30 visits, medical necessity review conducted to confirm medical necessity for any continued therapy care. Anthem Blue Cross <a href="#">preauthorization</a> required for all intensive out-patient and partial <a href="#">hospitalization</a> care.
	Inpatient services	10% <a href="#">coinsurance</a>	30% <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>	30% <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>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a> <sup>+</sup>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<sup>+</sup> Rest cures, custodial care, educational therapy, play therapy, or treatment of learning disabilities are not covered. <sup>+</sup> 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. Physician order specifying frequency and duration of treatment required when receiving therapy, such as physical, occupational, speech, etc. Therapy benefits must be performed by a licensed, certified practitioner within the scope of his/her license and is covered up to a maximum allowed amount of \$85 per visit.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Habilitation services</a> <sup>+</sup>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	

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

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most. Coinsurance amounts based on covered expenses.)	
	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 limited to one exam/year. Out-of-network reimbursement limited based on payment schedule.
	Children’s glasses	\$30 copayment	\$30 copayment	Coverage 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.)		
<ul style="list-style-type: none"><li>Charges in Excess of Usual, Customary and Reasonable Charges</li><li>Cosmetic Surgery, see Plan Booklet for details</li><li>Custodial Care</li></ul>	<ul style="list-style-type: none"><li>Expenses incurred not due to sickness or injury</li><li>Inpatient Private-Duty Nursing</li><li>Long-Term Care (i.e., in convalescent homes, nursing or rest homes or institutions of a similar nature)</li></ul>	<ul style="list-style-type: none"><li>Routine Foot Care, except special shoes/inserts relating to diabetes</li><li>Weight Loss Programs</li></ul>



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

- |   |                       |   |
|---|-----------------------|---|
| • Acupuncture                                       | • Dental Care (Adult) | • Non- <u>emergency services</u> when traveling outside the U.S. (e.g., doctor's visit) |
| • Bariatric Surgery (with <u>Preauthorization</u> ) | • Hearing Aids        |   |
| • Chiropractic Care                                 |                       | • 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 agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), 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>.

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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.*

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

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</a> [ <a href="#">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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:	
Cost Sharing	
<a href="#">Deductibles</a>	\$325.00
<a href="#">Copayments</a>	\$10.00
<a href="#">Coinsurance</a>	\$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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$325
■ <a href="#">Specialist</a> [ <a href="#">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*)  
Prescription drugs  
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600.00
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In this example, Joe would pay:	
Cost Sharing	
<a href="#">Deductibles</a>	\$325.00
<a href="#">Copayments</a>	\$770.00
<a href="#">Coinsurance</a>	\$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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$325
■ <a href="#">Specialist</a> [ <a href="#">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*)  
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800.00
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In this example, Mia would pay:	
Cost Sharing	
<a href="#">Deductibles</a>	\$325.00
<a href="#">Copayments</a>	\$60.00
<a href="#">Coinsurance</a>	\$240.00
What isn't covered	
Limits or exclusions	\$0.00
The total Mia would pay is	\$625.00