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 or call 1-877-866-2200. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, 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?	**$750** per person **$2,250** 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 co-payment if rendered by a network provider.	This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: **$9,450** per person There is an all-inclusive network out-of-pocket limit: **$9,450** per person / **$18,900** 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.
What is not included in the out-of-pocket limit?	Premiums, non-covered expenses, deductibles, and emergency room care co-payments. 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.

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

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. This plan covers network coverage only for medical benefits, including mental health and substance abuse benefits (with the exception of ACA required payments for Emergency Services). For a list of network providers, see dgaplans.org or call (800) 810-2583.	This plan only covers network medical coverage provided by Anthem Blue Cross. However, in emergencies, or for certain services at network facilities, you're also covered for treatment from non-network providers. This includes: 1) Emergency Services provided at a non-network facility, 2) Services/items provided by a non-network provider at a network facility, and 3) Non-network emergency air ambulance services. In these cases, non-network providers and facilities may not bill you for any amounts not covered (i.e., balance billing), and you will pay the same cost-sharing that applies to network claims.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

All **co-payment** and **co-insurance** 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most. Coinsurance amounts based on covered expenses.)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	Not Covered	None
	Specialist visit	30% coinsurance	Not Covered	
	Preventive care[1]/screening/ immunization	No Charge	Not Covered	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. Not all services are considered preventive when given with during a preventive screening and coinsurance may be applicable.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	
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	Network co-payment plus any charges exceeding network pharmacy rates.	Mail order/CVS Caremark Maintenance Choice: 90-day supply. Pharmacy: 30-day supply. Contraceptives :100% coverage.
	Preferred brand drugs	Mail order: $60/prescription Pharmacy: $24/prescription	Network co-payment plus all charges exceeding network pharmacy rates.	Mail order/CVS Caremark Maintenance Choice: 90-day supply. Pharmacy: 30-day supply.

[1] Includes preventive care services as recommended by the government. For a complete list of Preventive Care Services, visit https://www.uspreventiveservicestaskforce.org and look for "A" and "B" recommendations.

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

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. Coinsurance amounts based on covered expenses.)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at dgaplans.org	Non-preferred brand drugs	Mail order: $60/prescription Pharmacy:$24/prescription	Network co-payment plus all charges exceeding network pharmacy rates.	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.
	Specialty drugs	Mail order: $60/prescription Pharmacy: $24/prescription	Network co-payment plus all charges exceeding network pharmacy rates.	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. Not all specialty drugs are eligible for CVS Caremark PrudentRX.
If you have outpatient surgery	Facility fee (*e.g.,* ambulatory surgery center)	30% co-insurance	Not Covered	For non-network, only emergency care would be applicable.
	Physician/surgeon fees	30% co-insurance	Not Covered	For non-network, only emergency care would be applicable. Does not include hospitalization fees.
If you need immediate medical attention	Emergency room care	30% co-insurance	30% co-insurance	$50 co-payment applies and is only waived if admitted to the hospital.
	Emergency medical transportation	30% co-insurance	30% co-insurance	None
	Urgent care	30% co-insurance	Not Covered	
If you have a hospital stay	Facility fee (*e.g.,* hospital room)	30% co-insurance	30% co-insurance (only applicable for emergency care, does not apply to admissions.)	All inpatient admission into a network hospital will require preauthorization from Anthem Blue Cross.

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. Coinsurance amounts based on covered expenses.)	
	Physician/surgeon fees	30% co-insurance	30% co-insurance (only applicable for emergency care, does not apply to admissions.)	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% co-insurance	Not Covered	All intensive outpatient and partial hospitalization care will require preauthorization from Anthem Blue Cross.
	Inpatient services	30% co-insurance	Not Covered	All inpatient and residential admissions will require preauthorization from Anthem Blue Cross.
If you are pregnant	Office visits	30% co-insurance	Not Covered	Maternity care is not provided to dependent children, unless the dependent child has complications of pregnancy.
	Childbirth/delivery professional services	30% co-insurance	Not Covered	
	Childbirth/delivery facility services	30% co-insurance	Not Covered	
If you need help recovering or have other special health needs	Home health care†	30% co-insurance	Not Covered	†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 an 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
	Rehabilitation services	30% co-insurance	Not Covered	
	Habilitation services‡	30% co-insurance	Not Covered	

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. Coinsurance amounts based on covered expenses.)	Limitations, Exceptions, & Other Important Information
				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.
	Skilled nursing care	30% co-insurance	Not Covered	Coverage is limited to 860 hours/year for home nursing care.
	Durable medical equipment	30% co-insurance	Not Covered	Coverage is limited to the allowed amount.
	Hospice services	30% co-insurance	Not Covered	None
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.)

- Acupuncture
- Chiropractic
- Cosmetic Surgery, see Plan Booklet for details
- Custodial Care
- Dental Care
- Expenses incurred not due to sickness or injury
- Foot Orthotics
- Hearing Aids
- Inpatient Private-Duty Nursing
- Long-Term Care
- Non-network medical services
- Routine Eye Care
- Special arrangements with UCLA Health/EIMG
- Weight Loss Programs

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

- Bariatric Surgery (with Preauthorization)
- Emergency Services
- Prescription Drugs

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-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S.

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

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.

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, co-payments and co-insurance) 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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750.00
Co-payments	$10.00
Co-insurance	$3,430.00
What isn't covered	
Limits or exclusions	$60.00
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750.00
Co-payments	$730.00
Co-insurance	$250.00
What isn't covered	
Limits or exclusions	$230.00
The total Joe would pay is	**$1,960.00**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750.00
Co-payments	$60.00
Co-insurance	$600.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,410.00**

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