Writers' Guild-Industry Health Fund – Delta Dental of California

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/16 – 12/31/16
Coverage for: Individual + Dependents
Plan Type: Delta Preferred Option (DPO)

This is only a summary. If you want more information about these and other benefits (such as medical) please contact the Fund Office at (818) 846-1015 or (800) 227-7863 or through our website, **www.wgaplans.org**. Espanol: Para obtener asistencia en Espanol, llame al (818) 846-1015. There is a separate Summary for the Dental DHMO, and separate SBCs for the Medical PPO and Low Option Plans.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check the Plan's Summary Plan Description (SPD) or Summary of Benefits Summary (SOB) for additional details. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**Yes,** for Dental Services other than Diagnostic and Preventive services. In-Network: $75 Individual/$150 per Family each calendar year. $25 per Individual per lifetime for Orthodontia Services Out-of-Network: $75 Individual/$150 per Family each calendar year. $25 per Individual per lifetime for Orthodontia Services	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check the Fund's Summary Plan Description (SPD) or Summary of Benefits Summary (SOB) for additional details.
Is there an out–of–pocket limit on my expenses?	No	The **out-of-pocket limit** is the most you could pay per calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Not applicable.	Not applicable because there's no out-of-pocket limit on your expense.
Is there an overall annual limit on what the plan pays?		This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 3 describes specific coverage limits, such as limits on the number of office visits.

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Does this plan use a network of dental providers?	Yes, for a list, see www.deltadentalins.com or call (800) 335-8227	If you use an in-network dentist this plan will pay some or all of the costs of covered services.
Do I need a referral to see a dental specialist?	No	You can see a dental specialist you choose without permission from this Plan. Benefits are subject to the plan's coverage and benefit limitations. See the Fund's SPD for additional information.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 3. See the Plan's Summary of Plan Description (SPD) for additional information about **excluded services**.

- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a crown is $100, your **coinsurance** payment of 20% would be $20. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **dentist** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network provider charges $150 for a crown and the **allowed amount** is $100, you may have to pay the $50 difference. (This is called **balance billing**.)
- This plan encourages you to use Network dental providers by charging you lower **deductibles** and **coinsurance** amounts.

Common Dental Event	Services You May Need	Your cost if you use an In-network – Delta DPO Dentist	Your cost if you use an Out-of-network Provider – Non-Delta DPO Dentist/Non-Network Dental Providers	Limitations & Exceptions
If you visit a dental provider's office or clinic	Diagnostic and Preventive Benefits (includes xrays)	100% of DPO approved fee (no deductible applies)	80% of Delta-approved fee (no deductible applies)	For non-Delta network providers, you may be responsible for the amount over the approved fee
	Basic and Major Benefits	80% of DPO-approved fee	70% of Delta-approved fee	For non-Delta network providers, you are responsible for the remaining 30% plus fee above approved amount.

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Common Dental Event	Services You May Need	Your cost if you use an In-network – Delta DPO Dentist	Your cost if you use an Out-of-network Provider – Non-Delta DPO Dentist/Non-Network Dental Providers	Limitations & Exceptions
	Orthodontia Benefits	70% of DPO-approved fee. $2,000 Lifetime Maximum	70% of Delta-approved fee. 2,000 Lifetime Maximum	(Note: Coverage for children up to age 19 for all Delta and Non-Delta providers and non-network providers). 50% is payable at the time banding is done and the remaining 50% twelve months later.
	Dental work performed by a Pedodontist.	100% of Percentage of approved fee varies based on type of service	100% of Percentage of approved fee varies based on type of services	
If you have a test	Diagnostic test (x-ray)	Xray is included in the diagnostic and preventive benefits	Xray is included in the diagnostic and preventive benefits	
	Imaging (CT/PET scans, MRIs)	Not applicable	Not applicable	

Common Dental Event	Services You May Need	Your cost if you use an In-network – Delta DPO Dentist	Your cost if you use an Out-of-network Provider – Non-Delta DPO Dentist/Non-Network Dental Providers	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wgaplans.org	Generic drugs	Not applicable	Not applicable	*The following benefits are covered under the preventive care benefits at 100%, with no deductible: - Fluoride supplements for children without fluoride in their water. - Oral health risk assessment for young children. Applies to all drug types, in-network only. Processed by Express Scripts
	Preferred brand drugs	Not applicable	Not applicable	See above
	Non-preferred brand drugs	Not applicable	Not applicable	See above
	Specialty drugs	Not applicable	Not applicable	
If you have outpatient surgery	Oral Surgery	Covered under Major Services	Covered under Major Services	Subject to the plan's limitation and covered dental expenses. See the Plan's SPD or the Dental Evidence of Coverage (EOC) for details.
If you have a dental emergency	Emergency room services	Not applicable	Not applicable	
	Emergency medical transportation	Not applicable	Not applicable	

Common Dental Event	Services You May Need	Your cost if you use an In-network – Delta DPO Dentist	Your cost if you use an Out-of-network Provider – Non-Delta DPO Dentist/Non-Network Dental Providers	Limitations & Exceptions
	Urgent care	100% of Percentage of approved fee varies based on type of service	100% of Percentage of approved fee varies based on type of service	Emergency treatment should be used for temporary relief of pain only. The plan will reimburse up to 100% per emergency visit to an in-network provider and up to 80% per emergency visit to an out-of-network provider. See the Plan's SPD for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	Not applicable	
	Physician/surgeon fee	Not applicable	Not applicable	
If you have mental health, behavioral health, or substance	Mental/Behavioral health outpatient	Not applicable	Not applicable	
	Mental/Behavioral health inpatient	Not applicable	Not applicable	
	Substance use disorder outpatient	Not applicable	Not applicable	
	Substance use disorder inpatient services	Not applicable	Not applicable	
If you are pregnant	Prenatal and postnatal care	Not applicable	Not applicable	
	Delivery and all inpatient services	Not applicable	Not applicable	
If you need help recovering or have other special health needs	Home health care	Not applicable	Not applicable	
	Rehabilitation services	Not applicable	Not applicable	
	Habilitation services	Not applicable	Not applicable	
	Skilled nursing care	Not applicable	Not applicable	
	Durable medical equipment	Not applicable	Not applicable	
	Hospice service	Not applicable	Not applicable	
If your child needs dental or eye care	Eye exam/Glasses	Not applicable	Not applicable	
	Dental check-up	100%	Not applicable	

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the SPD for other excluded services.)

- Cosmetic surgery
- Private-duty nursing
- Infertility treatment
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Hearing Aids
- Chiropractic Care
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs
- Bariatric surgery, unless medically necessary

Other Covered Services (This isn't a complete list. Check the SPD document for other covered services and your costs for these services.)

- Dental Care

Your Rights to Continue Coverage:

"If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (818) 846-1015 or (800) 227-7863. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Writers' Guild-Industry Health Fund at (818) 846-1015 or (800) 227-7863.

If you have a complaint or are dissatisfied with a denial of coverage for claims under the DPO plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Delta Dental of California at (800) 335-8227 or on the website at deltadentalins.com or write Delta Dental at P.O. Box 997330, Sacramento, CA 95899-7330. If dissatisfied, you can also contact the Writers' Guild-Industry Health Fund at (818) 846-1015 or (800) 227-7863 or visit our website at www.wgaplans.org.

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

Note: These examples do not specifically apply to the dental benefits under the Dental DPO.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care **will also be different.**

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,025
- **Patient pays** $1,425

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$ 40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$125
Coinsurance	$1,000
Limits or exclusions	$0
Total	**$1,425**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $3,494
- **Patient pays** $606

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$300
Copays	$25
Coinsurance	$281
Limits or exclusions	$0
Total	**$606**

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**.

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