



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 DPO, and separate SBCs for the Medical PPO and Low Option Plans.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 3 for your costs for services this plan covers.
Are there other deductibles for specific services?	No, the DHMO Plan has no deductible.	
Is there an out-of-pocket limit on my expenses?	No, the DHMO Plan has no out-of-pocket limit.	
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?	No, the DHMO Plan does not have a benefit maximum.	Not applicable
Does this plan use a network of dental providers?	Yes, for a list of Delta Dental dentists, see www.deltadentalins.com or call 800-335-8227	You must use the providers contracted with the DHMO plan.
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.
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 .

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- **Co-payment** is a fixed-dollar amount that you pay your contract dentist for certain eligible expenses at the time the services is provided.
- **Filed Fees** is any procedure not listed in the EOC is considered not a covered benefit and you will be charged a “Filed Fee” for that service. This means the fee your contract dentist will charge has been filed with Delta Dental and your dentist cannot charge you more than the “Filed Fee”.
- You will incur an additional charge if you request your contract dentist to perform an **alternative procedure** that satisfies the same dental need as a covered procedure (i.e., a composite filling instead of an amalgam filling). Your contract dentist will charge you the difference between his/her “**Filed Fee**” for the “Optional” procedure and the “**Filed Fee**” for the “**Covered**” procedure, plus any applicable “**Copayment**” for the covered procedure.

Common Dental Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network – Delta DHMO Dentist	Out-of-network Provider	
If you visit a dental provider’s office or clinic	Diagnostic Benefits (including xrays)	100%	Not applicable	
	Preventive & Restorative Benefits	100% of allowed fee.	Not applicable	See Delta’s Evidence of Coverage (EOC) for specific services that require a copayment.
	Endodontics & Prosthodontics Benefits	100% of allowed fee.	Not applicable	See the Dental EOC for specific services that require a copayment.
	Orthodontics Benefits	100% of allowed fee.	Not applicable	See the Dental EOC for specific services that require a copayment.
If you have a test	Diagnostic test (x-ray)	Covered under diagnostic benefits.	Not applicable	
	Imaging (CT/PET scans, MRIs)	Not applicable	Not applicable	

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

(California only)

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: Dental DHMO (DeltaCare)

Common Dental Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network – Delta DHMO Dentist	Out-of-network Provider	
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	*See Summary Plan Description (SPD) for list of over-the-counter drugs available through INN pharmacy with Rx. <ul style="list-style-type: none"> – Prior Authorization: Hepatitis C drugs and Compound Drugs – All drugs on the Express Script Exclusion List are a non-covered expense.
	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 and Maxillofacial Surgery	100% of allowed fee.	Not applicable	See the Dental EOC for specific services that require a copayment.
If you have a dental emergency	Emergency room services	Not applicable	Not applicable	
	Emergency medical transportation	Not applicable	Not applicable	
	Urgent care	100%, less \$100 copayment.	Not applicable	Emergency treatment should be used for temporary relief of pain only. The DHMO plan will reimburse up to \$100 per emergency, per enrollee for services performed by a non-network dentist under certain circumstances. After you receive emergency care, you must contact your primary dentist to discuss any follow-up treatment.

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Plan Type: Dental DHMO (DeltaCare)

Common Dental Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network – Delta DHMO Dentist	Out-of-network Provider	
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 abuse needs	Mental/Behavioral health outpatient	Not applicable	Not applicable	
	Mental/Behavioral health inpatient services	Not applicable	Not applicable	
	Substance use disorder outpatient services	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	Covered under the Dental Plan*	Not applicable	*In-network oral health risk assessment for young children is covered under the Preventive Care benefits at 100%. No cost sharing as defined by federal law.

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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
- Bariatric surgery, unless medically necessary
- Chiropractic Care
- Routine eye care (Adult)
- Routine foot care
- Hearing Aids
- Weight Loss Programs

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 the DHMO 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 your 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 DHMO.



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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