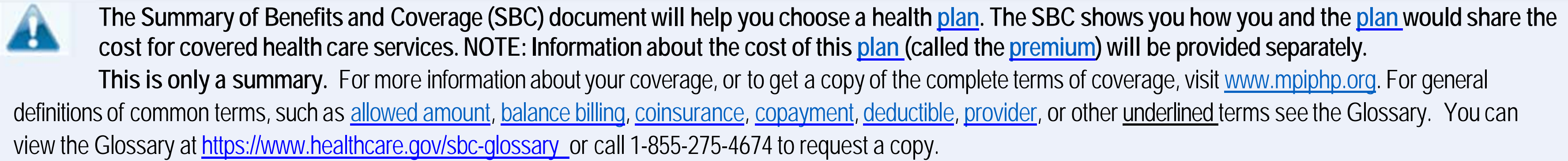


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.mpiphp.org. 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 1-855-275-4674 to request a copy.

Important Questions	Answers	Why this matters
What is the overall deductible?	$0	See the Common Medical Events charge below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Deductible not applicable.	This plan does not have a deductible, but a copayment or coinsurance may apply.
Are there deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,000 In-Network No limit Out-of-Network	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, copayments, balance-billing charges and health benefits this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com for a list of network providers.	You pay the least if you use a provider in Motion Picture Preferred Provider (MP3) network. You pay more if you use a provider in Anthem Blue Cross network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No. However, by getting a referral for a Motion Picture Preferred Provider (MP3) Participants can save out-of-pocket costs.	You can see the specialist you choose without a referral.

Note: For more information about limitations and exceptions, see the plan or policy document at www.mpiphp.org.

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 Will You Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**MP3:** $5 copayment **Other**: 10% coinsurance plus $30/$15 copayment	50% coinsurance plus $30/$15 copayment, plus balance billing	Out-of-network provider's allowable amount is based on "reasonable and customary" rates. $30 co-payment for patients living in MPTF Service Area, $15 co-payment for patients living outside the MPTF Area.
	Specialist visit	**MP3:** $5 copayment (with referral) **Other:** 10% coinsurance plus copayment	50% coinsurance plus copayment, plus balance billing	Out-of-network provider's allowable amount is based on "reasonable and customary" rates.
	Preventative care/screening/ immunization	**MP3:** $5 copayment **Other:** 10% coinsurance plus copayment	50% coinsurance plus copayment, plus balance billing	Adult immunizations are limited by the Summary Plan Description and Summaries of Material Modification. Comprehensive Physical Exams (CPE) for adults who reside within Los Angeles County may be performed through at the UCLA-Motion Picture & Television Fund Health Centers for a $5 co-payment.
ment If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance[1]	50% coinsurance, plus balance billing	Must be prescribed by a physician.
	Imaging (CT/PET scans, MRIs)	10% coinsurance[1]	50% coinsurance, plus balance billing	Must be prescribed by a physician.
		CVS Contracted Pharmacy	**Non-Contracted Pharmacy**	
If you need drugs to treat your illness or condition	Generic Drugs	$10 prescription	Not covered	Up to a 30-day supply at any participating retail pharmacies.
	Preferred Brand Drugs	$25 prescription	Not covered	Up to a 30-day supply at any participating retail pharmacies.
	All Other Brand Drugs	$40 prescription	Not covered	Up to a 30-day supply at any participating retail pharmacies.
CVS Caremark Prescription Drug Benefit – Active Plan	Generic Drugs	$25 prescription	Not covered	Up to 90-day supply, through CVS Caremark mail-order pharmacy or at a CVS retail pharmacy location.
	Preferred Brand Drugs	$65 prescription	Not covered	Up to 90-day supply, through CVS Caremark mail- order pharmacy or at a CVS retail pharmacy location.

[1] Professional services may be 0% coinsurance with a referral to an MP3 network provider; technical and facility services are always 10% coinsurance in-network.

	All Other Brand Drugs	$100 prescription	Not covered	Up to 90-day supply, through CVS Caremark mail-order pharmacy or at a CVS retail pharmacy location.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Plan covers up to a maximum benefit of $350	For out-of-network provider: up to the maximum benefit noted, plus balance billing may apply.
	Physician/surgeon fees	10% coinsurance plus copayment[1]	50% coinsurance plus balance billing	For the second (or more) procedure(s) patient coinsurance is 75%.
If you need immediate medical attention	Emergency room care	10% coinsurance plus $100 copayment	10% coinsurance, $100 copayment, plus balance billing *may apply*	If the emergency services qualify for the No Surprises Act, (NSA) there will be no balance billing.
	Emergency medical transportation	10% coinsurance	10% coinsurance plus balance billing	If services qualify for NSA, there will be no balance billing.
	Urgent care	10% coinsurance plus copayment[1]	50% coinsurance plus balance billing	Exer Urgent Care facilities are a flat $15 copayment
	Telemedicine	$5 copayment if using Live Health On-Line; for regular provider visits, same as office visit.	Not covered	Available through Live Health Online, or through regular provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance plus $100 copayment	50% coinsurance, $100 copayment, plus balance billing	See Summary Plan Description for exclusions, including investigational procedures, beginning on page 80.
	Physician/surgeon fees	10% coinsurance plus copayment[1]	50% coinsurance, copayment, plus balance billing	
If you need mental health, behavioral health, or substance abuse	Outpatient services	$5 copayment	50% coinsurance	Benefits through OptumHealth 1-800-888-2998, www.optum.com
	Inpatient services	$0	50% coinsurance, copayment, plus balance billing	
If you are pregnant	Office visits	10% coinsurance plus copayment[1]	50% coinsurance, copayment, plus balance billing	Depending on the type of services, a copayment, may apply. Dependent children are excluded from this coverage.
	Childbirth/delivery professional services	10% coinsurance plus copayment[1]	50% coinsurance, copayment, plus balance billing	
	Childbirth/delivery facility services	10% coinsurance plus copayment[1]	50% coinsurance, $100 copayment, plus balance billing	

If you need help recovering or have other special health needs	Home health care	10% coinsurance for nurse; 10% coinsurance plus copayment for physician[1]	50% coinsurance, copayment, plus balance billing	Nursing assistants and nursing aides are plan exclusions.
	Rehabilitation services	10% coinsurance plus copayment[1]	50% coinsurance, copayment, plus balance billing	Physical/Occupational/Aquatic/Osteopathic manipulative therapies are limited. Limited to 16 treatments annually. Cardiac rehabilitation is limited to 32 treatments per lifetime.
	Habilitation services	10% coinsurance plus copayment[1]	50% coinsurance, copayment, plus balance billing	
	Skilled nursing care	10% coinsurance[1]	50% coinsurance plus balance billing	Participants - 90 days annually Dependents - 60 days annually $100 copayment, waived if transferred to a facility. The minimum requirements are 3 days inpatient and should be admitted within 30 days.
	Durable medical equipment	10% coinsurance	50% coinsurance plus balance billing	Durable medical equipment may be purchased or rented once every two years. For more, see page 70 of the Summary Plan Description.
	Hospice services	0%	0%	Home Hospice only
If your child needs dental or eye care	Children's eye exam (VSP Vision Services) 1-800-877-7195	$20 copayment Exam once per year	Pay in full and submit itemized receipt to VSP. You will receive lesser benefit when using non VSP provider	VSP Vision Services – (800) 877-7195 Exam covered only once per year. Eye exams required by an employer and medical or surgical treatment of eyes is covered under the MPI Health Plan.
	Children's glasses (VSP Vision Services) 1-800-877-7195	$20 copayment, frames covered up to $200, lenses - $0 Every calendar year your benefit allows you to receive either contact lenses and a fitting and evaluation at an allowance of $105.	Pay in full and submit itemized receipt to VSP. You will receive lesser benefit when using non-VSP provider	Only covered through VSP. Lenses covered only once per year and frames once every two years. Corrective eyewear required by an employer and replacement lenses or frames not covered.
	Children's dental checkup (Delta Dental PPO) 1-800-335-8227	20% of the Usual, Customary and Reasonable Rate (UCR) $25 annual deductible per person; up to a $50 maximum per family	Lesser of UCR rates; $25 annual deductible per person; up to a $50 maximum per family (out-of-network deductible is combined with in-network deductible)	Maximum of $2,000 per person per calendar year.
	Children's dental checkup (DeltaCare USA – CA only) 1-800-422-4234	0% / No deductible	No benefit	Must use selected DeltaCare affiliated dentists only; dentists are located throughout California

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check you policy or plan document for more information and a list of any other excluded services)

- Cosmetic surgery
- Experimental/Investigational Procedures
- Weight Loss Programs, Drugs and Surgeries
- Homeopathic Treatment
- Long Term Care
- Infertility treatment
- See Summary Plan Description pages 80-81
- Private-duty nursing

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

- Acupuncture
- Routine foot care
- Chiropractic care (with limitations)
- Hearing aids
- Dental care (Adult)
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 our plan office at 855-ASK-4MPI (855-275-4674).

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 http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.]

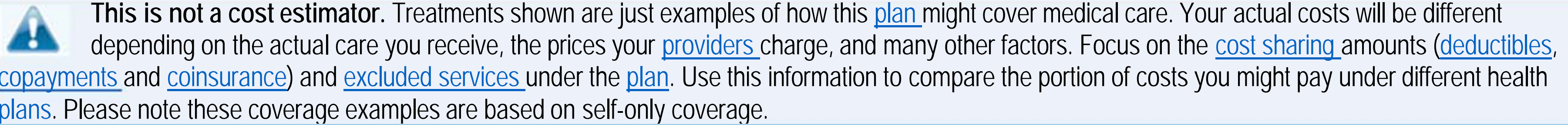
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.]

To see examples of how this plan might cover costs for 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, 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 plan's overall deductible — $0
- Specialist copayment — $30
- Hospital (facility) coinsurance — 10%
- Other coinsurance — 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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$190
Coinsurance	$1,000
What is not covered	
Limits or exclusions	$100
The total Peg would pay is	**$1,290**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible — $0
- Specialist copayment — $30
- Hospital (facility) coinsurance — 10%
- Other coinsurance — 10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs[2]
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$510
Coinsurance	$370
What is not covered	
Limits or exclusions[2]	**$4300**
The total Joe would pay is	**$5,180**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible — $0
- Specialist copayment — $30
- Emergency Room copayment — $100
- Hospital (facility) coinsurance — 10%
- Other copayment — 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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$190
Coinsurance	$190
What is not covered	
Limits or exclusions	**$100**
The total Mia would pay is	**$480**

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

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[2] Prescription cost is covered through CVS Caremark.