Motion Picture Industry Health Plan: Anthem Blue Cross - Active Employees

Coverage for: ____________ | Plan Type: _____

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, 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 chart 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 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?	$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 - 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 for a list of network providers.	You pay the least if you use a provider in MPTF/TIHN 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 an Industry Health Network (TIHN) provider, Participants can save out-of-pocket costs.	You can see the specialist you choose without a referral.

* For more information about limitations and exceptions, see the plan or policy document at www.mpiphp.org.
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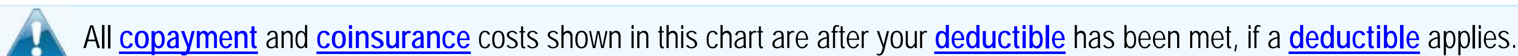
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	**MPTF/TIHN**: $5 co-pay **Other**: 10% coinsurance plus $30/15 co-pay	50% coinsurance plus $30/15 co-pay, plus Balance Billing	Out-of-network providers allowable amount based on "reasonable and customary" rates. $30 for patients living in MPTF Service Area, $15 for patients living outside the MPTF Area
	Specialist visit	**MPTF/TIHN**: $5 co-pay (with referral) **Other**: 10% coinsurance plus co-pay	50% coinsurance plus co-pay, plus Balance Billing	Out-of-network providers allowable amount based on "reasonable and customary" rates
	Preventive care/screening/ immunization	**MPTF/TIHN**: $5 co-pay **Other**: 10% coinsurance plus co-pay	50% coinsurance plus co-pay, plus Balance Billing	Adult immunizations are limited by the Summary Plan Description and Summaries of Material Modification. Comprehensive Physical Exams for adults who reside within Los Angeles County must be performed through the Wellness Program at the Motion Picture & Television Funds.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance**	50% coinsurance, plus Balance Billing	Must be prescribed by a physician
	Imaging (CT/PET scans, MRIs)	10% coinsurance**	50% coinsurance	Must be prescribed by a physician
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com.	Generic drugs	**Retail**: $10 co-pay **Mail Order**: $25 co-pay (90 day supply)	**Retail**: $10 co-pay	The first two times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co-pay for up to a 30 day supply. After the second purchase at retail, you are required to use mail order through Express Scripts, or Walgreens, Duane Reade, or other pharmacies participating in Express Scripts Smart-90 network. Otherwise, you'll pay the entire cost if you continue to purchase it at retail.
	Preferred brand drugs	**Retail**: $25 co-pay **Mail Order**: $65 co-pay (90 day supply)	**Retail**: $25 co-pay	
	Non-preferred brand drugs	**Retail**: $40 co-pay **Mail Order**: $100 co-pay (90 day supply)	**Retail**: $40 co-pay	

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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)	
	Specialty drugs	**Retail**: $40 co-pay **Mail Order**: $100 co-pay (90 day supply)	**Retail**: $40 co-pay	If you purchase a brand-name medication when a generic medication is available, you will pay the generic co-payment, plus the difference in cost between the brand and the generic. Prior authorization is required for some medications including compounds and most specialty drugs.
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 co-pay**	50% coinsurance plus Balance Billing	For the second (or more) procedure(s) patient coinsurance is 75%

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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)	
If you need immediate medical attention	Emergency room care	10% coinsurance plus $100 co-pay	10% coinsurance, $100 co-pay, plus Balance Billing	
	Emergency medical transportation	10% coinsurance	10% coinsurance, plus Balance Billing	
	Urgent care	10% coinsurance plus co-pay**	50% coinsurance, co-pay, plus Balance Billing	Exer Urgent Care facilities are a flat $15 co-pay
	Telemedicine	$20 co-pay	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance plus $100 co-pay	50% coinsurance, $100 co-pay, plus Balance Billing	See Summary Plan Description for exclusions, including investigational procedures, beginning on page 63.
	Physician/surgeon fees	10% coinsurance plus co-pay**	50% coinsurance, co-pay, plus Balance Billing	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 co-pay	50% coinsurance	Benefits through OptumHealth 1-800-888-2998, www.optumhealth.com
	Inpatient services	$0	50% coinsurance plus co-pay, plus Balance Billing	
If you are pregnant	Office visits	10% coinsurance plus co-pay**	50% coinsurance plus co-pay, plus Balance Billing	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Dependent children are excluded from this coverage.
	Childbirth/delivery professional services	10% coinsurance plus co-pay**	50% coinsurance plus co-pay, plus Balance Billing	
	Childbirth/delivery facility services	10% coinsurance plus $100 co-pay	50% coinsurance plus $100 co-pay, plus Balance Billing	
If you need help recovering or have other special health needs	Home health care	10% coinsurance for nurse; 10% coinsurance plus co-pay for physician**	50% coinsurance plus co-pay, plus Balance Billing	Nursing assistants and nursing aides are Plan exclusions.
	Rehabilitation services	10% coinsurance plus co-pay**	50% coinsurance plus co-pay, 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 co-pay**	50% coinsurance plus co-pay, plus Balance Billing	
	Skilled nursing care	10% coinsurance**	50% coinsurance, plus Balance Billing	Participants - 90 days annually Dependents - 60 days annually

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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)	
	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 57 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 co-pay Exam once per year	$20 co-pay Reimburse up to $40	VSP Vision Services – 1-800-877-7195 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	$20 co-pay Frames covered up to $145 Lenses - $0	Frames covered up to $55 Single vision lenses – covered up to $40	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 check-up (Delta Dental PPO) 1-800-335-8227	0% of allowable rate for PPO; 20% of allowable rate for Premier PPO; $25 annual deductible per person; up to a $50 maximum per family	50% 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 check-up (DeltaCare USA – CA only) 1-800-422-4234	0% / No deductible	No benefit	

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.)

- Cosmetic Surgery
- Experimental/Investigational Procedures
- Bariatric surgery
- Weight Loss Programs, Drugs, and Surgeries
- Homeopathic Treatment
- Long-term care
- Infertility treatment
- See S.P.D. Active Participants pages 63—64.
- Private-duty nursing

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

- Acupuncture (with limitations)
- Routine foot care
- Chiropractic care (with limitations)
- Hearing aids
- Dental care (Adult)
- Routine eye care (Adult)

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• Non-emergency care when traveling outside the U.S.	• Orthotics (with limitations)

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 a sample medical situation, see the next section.——————————————

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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 *co-pay* $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 isn't 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 *co-pay* $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
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 isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$980**

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

- The plan's overall deductible $0
- Specialist *co-pay* $30
- Emergency Room *co-pay* $100
- Hospital (facility) *coinsurance* 10%
- Other *coinsurance* 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 isn't covered	
Limits or exclusions	$100
The total Mia would pay is	**$480**

The plan would be responsible for the other costs of these EXAMPLE cover