 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](http://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 <a href="#">plan</a> covers.
Are there services covered before you meet your deductible?	<a href="#">Deductible</a> not applicable.	This <a href="#">plan</a> does not have a <a href="#">deductible</a> , but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there <a href="#">deductibles</a> for specific services?	No.	You do not have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,000 per person In-Network No limit <a href="#">Out-of-Network</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If services qualify for NSA, there will be no balance billing.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">copayments</a> , <a href="#">balance-billing</a> charges and health benefits this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> for a list of <a href="#">network providers</a> . Or visit <a href="http://www.mpiphp.org">www.mpiphp.org</a> for a list of MP3 Providers	You pay the least if you use a <a href="#">provider</a> in Motion Picture Preferred Provider (MP3) network. You pay more if you use a <a href="#">provider</a> in Anthem Blue Cross network. You will pay the most if you use an out-of-network provider balance billing may apply. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). <del>Check with your provider before you get services.</del>
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a referral. However, by getting a referral for a Motion Picture Preferred Provider (MP3) Participants can save out-of-pocket costs.

Note: For more information about limitations and exceptions, see the plan or policy document at [www.mpiphp.org](http://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	<b>MP3:</b> \$5 <a href="#">copayment</a> <b>Other:</b> 10% <a href="#">coinsurance</a> plus \$15/\$30 <a href="#">copayment</a> <sup>2</sup>	50% <a href="#">coinsurance</a> plus \$15/\$30 <a href="#">copayment</a> , plus <a href="#">balance billing</a> may apply.	<a href="#">Out-of-network provider's allowable amount</a> is based on "reasonable and customary" rates for Participants living in MP3 area \$30 copay and Participants outside MP3 area \$15 copay
	<a href="#">Specialist</a> visit	<b>MP3:</b> \$5 <a href="#">copayment</a> (with <a href="#">referral</a> ) <b>Other:</b> 10% <a href="#">coinsurance</a> plus <a href="#">copayment</a> \$15/ \$30 <sup>2</sup>	50% <a href="#">coinsurance</a> plus \$15/\$30 <a href="#">copayment</a> , <a href="#">balance billing</a> may apply.	<a href="#">Out-of-network provider's allowable amount</a> is based on "reasonable and customary" rates.
	Preventative care/screening/immunization	<b>MP3:</b> \$5 <a href="#">copayment</a> <b>Other:</b> 10% <a href="#">coinsurance</a> plus <a href="#">copayment</a> \$15 / \$30 / \$100 <sup>2</sup>	50% <a href="#">coinsurance</a> plus <a href="#">copayment</a> \$15/ \$30/\$100, <a href="#">balance billing</a>	Immunizations are covered under CDC Guidelines at the time of service.  Comprehensible Physical Exams (CPE) for adults living in Los Angeles County will have a \$100 copay when services NOT rendered by MP3 primary Care Provider
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a> <sup>1</sup>	50% <a href="#">coinsurance</a> , plus <a href="#">balance billing</a>	Must be prescribed by a physician.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> <sup>1</sup>	50% <a href="#">coinsurance</a> , plus <a href="#">balance billing</a>	Must be prescribed by a physician.
If you need drugs to treat your illness or condition				
	<b>Tier 1: Generic Drugs</b>	\$10 copay / 30 day supply \$25 copay / 90 day supply	Not Covered	Up to 90-day supply, through CVS Caremark mail-order pharmacy or at a CVS retail pharmacy location.
	<b>Tier 2: Preferred Brand Drugs</b>	\$25 copay / 30 day supply \$65 copay / 90 day supply	Not Covered	Up to 90-day supply, through CVS Caremark mail-order pharmacy or at a CVS retail pharmacy location.

	<b>Tier 3: Non-Preferred Brand Drugs</b>	\$40 copay / 30 day supply \$100 copay / 90 day supply	Not covered	Up to 90-day supply, through CVS Caremark mail-order pharmacy or at a CVS retail pharmacy location.
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<sup>1</sup> Professional services may be 0% coinsurance with a referral to an MP3network provider; technical and facility services are always 10% coinsurance in-network.

<sup>2</sup> Where a patient "resides" is based on his or her address on file with the Motion Picture Industry Health Plan.

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	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> , balance billing may apply.	Out-of-Network ASC is paid at 100% of the Allowable Amount up to a maximum benefit of \$350, balance billing may apply.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> plus <a href="#">copayment</a> <sup>1</sup>	50% <a href="#">coinsurance</a> plus <a href="#">copayment</a> and <a href="#">balance billing may apply</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> plus \$100 <a href="#">copayment</a>	10% <a href="#">coinsurance</a> , \$100 <a href="#">copayment</a>	If the emergency services qualify for the No Surprises Act, (NSA) there will be no balance billing.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> plus <a href="#">balance billing</a>	For Air Transportation: If services qualify for NSA, there will be no balance billing.
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a> plus <a href="#">copayment</a>	50% <a href="#">coinsurance</a> plus <a href="#">copayment</a> and <a href="#">balance billing may apply</a> .	Exer Urgent Care facilities are a flat \$15 <a href="#">copayment</a>
	Televisits	\$5 <a href="#">copayment available through Live Health On-Line</a> ; payable at 100% In-Network: 10% <a href="#">coinsurance</a> plus <a href="#">copayments</a>	50% <a href="#">coinsurance</a> plus <a href="#">copayments</a> , <a href="#">balance billing may apply</a> .	Telemedicine refers to a visit with a third-party vendor, such as LiveHealth Online. Televisit is with your regular physician and is covered in the same manner as physician visits .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> plus \$100 <a href="#">copayment</a>	50% <a href="#">coinsurance</a> , \$100 <a href="#">copayment</a> , plus <a href="#">balance billing</a>	See Summary Plan Description for exclusions, including investigational procedures.  If the services qualify for the No Surprises Act, (NSA) there will be no balance billing.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> plus <a href="#">copayment</a> <sup>1</sup>	50% <a href="#">coinsurance</a> , <a href="#">copayment</a> , plus <a href="#">balance billing</a>	
If you need mental health, behavioral health, or substance abuse	Outpatient services	\$5 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	Benefits through OptumHealth (888) 661-9141 <a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a>
	Inpatient services	\$0	50% <a href="#">coinsurance</a> , \$100 <a href="#">copayment</a> , plus <a href="#">balance billing</a>	

If you are pregnant	Office visits	10% <a href="#">coinsurance</a> plus <a href="#">copayment</a> <sup>1</sup>	50% <a href="#">coinsurance</a> , <a href="#">copayment \$15/ \$30</a> , plus <a href="#">balance billing</a> may apply	Depending on the type of services, a <a href="#">copayment</a> , may apply. Dependent children and surrogates are excluded from this coverage.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> , <a href="#">copayment \$15/ \$30</a> , <a href="#">balance billing</a> may apply	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> , \$100 <a href="#">copayment</a>	50% <a href="#">coinsurance</a> , \$100 <a href="#">copayment</a> , <a href="#">balance billing</a> may apply	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> for nurse; 10% <a href="#">coinsurance</a> plus <a href="#">copayment</a> for physician <sup>1</sup>	50% <a href="#">coinsurance</a> , <a href="#">copayment \$15/ \$30</a> , <a href="#">balance billing</a> may apply	Nursing assistants and nursing aides are <a href="#">plan</a> exclusions.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a> plus <a href="#">copayment</a> <sup>1</sup>	50% <a href="#">coinsurance</a> , <a href="#">copayment \$15/ \$30</a> , <a href="#">balance billing</a> may apply	Physical/Occupational/Aquatic/Osteopathic manipulative therapies are limited, 16 treatments annually. Speech therapy is limited to 32 treatments annually. Cardiac rehabilitation is limited to 36 treatments.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a> plus <a href="#">copayment</a> <sup>1</sup>	50% <a href="#">coinsurance</a> , <a href="#">copayment \$15/ \$30</a> , <a href="#">balance billing</a> may apply	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> , plus \$100 <a href="#">copayment</a>	50% <a href="#">coinsurance</a> plus \$100 <a href="#">copayment</a> , <a href="#">balance billing</a> may apply	Participants - 90 days annually per stay Dependents - 60 days annually per stay  <a href="#">Copayment</a> , waived if transferred to a facility. The minimum requirements are 3 days inpatient and should be admitted within 30 days. Custodial care is not covered
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> plus <a href="#">balance billing</a>	Durable medical equipment may be purchased or rented once every two years. For more information, see the Summary Plan Description.
	<a href="#">Hospice services</a>	0%	0%	Home Hospice only

<b>Dental and Vision needs</b>	Eye exam ( <a href="#">VSP Vision Services</a> ) 1-800-877-7195	\$20 <a href="#">copayment</a> Exam once per year	Pay in full and submit itemized receipt to VSP. You will receive lesser benefit when using non VSP provider	
	Glasses ( <a href="#">VSP Vision Services</a> ) 1-800-877-7195	Frames covered up to \$200 once every two years.  Every calendar year your benefit allows you to receive contact Lenses, a fitting, and evaluation at an allowance of \$195.	Pay in full and submit itemized receipt to VSP.	In network only covered through VSP. Out-of-network you will receive lesser benefit when using non- VSP provider. VSP will reimburse you up to the amounts allowed under your Plan's Out-of-Network reimbursement schedule. Corrective eyewear required by an employer and replacement lenses or frames not covered.
	Dental checkup ( <a href="#">Delta Dental PPO</a> ) (888) 335-8227	20% -30% of the contracted amount  \$25 annual <a href="#">deductible</a> per person; up to a \$50 maximum per family	50% Usual, Customary and Reasonable rates (UCR)  \$25 annual deductible per person; up to a \$50 maximum per family	Maximum of \$2,500 per person per calendar year.  In network and Out-of-network deductible is combined.
	Dental checkup ( <a href="#">DeltaCare USA</a> – CA only) 1-800-422-4234	0% / No <a href="#">deductible</a>	No benefit	Must use selected <a href="#">DeltaCare</a> affiliated dentists only; dentists are located throughout California

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check you policy or plan document for more information and a list of any other <a href="#">excluded services</a>)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Experimental/Investigational Procedures</li> </ul>	<ul style="list-style-type: none"> <li>• Weight Loss Programs, Drugs</li> <li>• Homeopathic Treatment</li> <li>• Long Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• See Summary Plan Description</li> <li>• Private-duty nursing</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your <a href="#">plan</a> document)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (with limitations)</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (with limitations)</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care</li> <li>• Routine eye care</li> <li>• Orthodontics (with limitations)</li> </ul>

### 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](http://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](http://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](http://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): Para makita ang mga detalye ng mga serbisyo, 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, kwijigo holne' <http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html>.]

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To see examples of how this plan might cover costs for 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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall deductible	\$0	■ The <a href="#">plan's</a> overall deductible	\$0	■ The <a href="#">plan's</a> overall deductible	\$0
■ <a href="#">Specialist copayment</a>	\$30	■ <a href="#">Specialist copayment</a>	\$30	■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	10%	■ Hospital (facility) <a href="#">coinsurance</a>	10%	■ <a href="#">Emergency Room</a> copayment	\$100
■ Other <a href="#">coinsurance</a>	10%	■ Other <a href="#">coinsurance</a>	10%	■ Hospital (facility) <a href="#">coinsurance</a>	10%
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs<sup>2</sup>                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$190	Copayments	\$510	Copayments	\$190
Coinsurance	\$1,000	Coinsurance	\$370	Coinsurance	\$190
<i>What is not covered</i>		<i>What is not covered</i>		<i>What is not covered</i>	
Limits or exclusions	\$100	Limits or exclusions <sup>2</sup>	\$4300	Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$1,290</b>	<b>The total Joe would pay is</b>	<b>\$5,180</b>	<b>The total Mia would pay is</b>	<b>\$480</b>

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

<sup>2</sup> Prescription cost is covered through CVSCaremark.