




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. 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 care 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. You pay more if you use a provider in Anthem Blue Cross. 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 .

 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	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	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	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 at the Wellness Program UCLA / Motion Picture & Television Fund health centers.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	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 Mail Order: \$25 co-pay (90 day supply)	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 or 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 Mail Order: \$65 co-pay (90 day supply)	
	Non-preferred brand drugs	Retail: \$40 co-pay Mail Order: \$100 co-pay (90 day supply)	Retail: \$40 co-pay Mail Order: \$100 co-pay (90 day supply)	If you purchase a brand-name medication when a generic medication is available, you will pay the generic co-payment, plus the

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

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 Mail Order: \$100 co-pay (90 day supply)	difference in cost between the brand and the generic. Prior authorization is required for some medications including compounds and most specialty drugs such as Hepatitis C 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
	Physician/surgeon fees	10% coinsurance plus co-pay	50% coinsurance plus co-pay	For the second (or more) procedure(s) patient coinsurance is 75%
If you need immediate medical attention	Emergency room care	10% coinsurance plus \$100 co-pay	10% coinsurance plus \$100 co-pay	
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance plus co-pay	50% coinsurance plus co-pay	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 plus \$100 co-pay	See Summary Plan Description for exclusions, including investigational procedures, beginning might be a different page
	Physician/surgeon fees	10% coinsurance plus co-pay	50% coinsurance plus co-pay	
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	
If you are pregnant	Office visits	10% coinsurance plus co-pay	50% coinsurance plus co-pay	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Dependent children are excluded from this coverage.
	Childbirth/delivery professional services	10% coinsurance plus co-pay	50% coinsurance plus co-pay	
	Childbirth/delivery facility services	10% coinsurance plus \$100 co-pay	50% coinsurance plus \$100 co-pay	
If you need help recovering or have other special health needs	Home health care	10% coinsurance plus co-pay	50% coinsurance plus co-pay	Nursing assistants and nursing aides are Plan exclusions.
	Rehabilitation services	10% coinsurance plus co-pay	50% coinsurance plus co-pay	Physical/Occupational/Aquatic/

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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)	
	Habilitation services	10% coinsurance plus co-pay	50% coinsurance plus co-pay	Osteopathic manipulative therapies are limited. Limited to 16 treatments annually. Cardiac rehabilitation is limited to 32 treatments per lifetime.
	Skilled nursing care	10% coinsurance	50% coinsurance	Participants - 90 days annually Dependents - 60 days annually
	Durable medical equipment	10% coinsurance	50% coinsurance	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 (Delta Dental USA – CA only) 1-800-422-4234	0% / No deductible	No benefit	

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

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 .)		
<ul style="list-style-type: none">• Cosmetic Surgery• Experimental/Investigational Procedures• Bariatric surgery	<ul style="list-style-type: none">• Weight Loss Programs, Drugs, and Surgeries• Homeopathic Treatment• Long-term care	<ul style="list-style-type: none">• Infertility treatment• See S.P.D. Active Participants pages 62—64.• Private-duty nursing
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Acupuncture (with limitations)• Routine foot care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Chiropractic care (with limitations)• Hearing aids• Orthotics (with limitations)	<ul style="list-style-type: none">• 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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, kwijigo 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.*-----

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 <i>co-pay</i>	\$30
■ Hospital (facility) <i>coinsurance</i>	10%
■ Other <i>coinsurance</i>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$190
Coinsurance	\$1,000
<i>What isn't covered</i>	
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 <i>co-pay</i>	\$30
■ Hospital (facility) <i>coinsurance</i>	10%
■ Other <i>coinsurance</i>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$510
Coinsurance	\$370
<i>What isn't covered</i>	
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 <i>co-pay</i>	\$30
■ Emergency Room <i>co-pay</i>	\$100
■ Hospital (facility) <i>coinsurance</i>	10%
■ Other <i>coinsurance</i>	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$190
Coinsurance	\$190
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Mia would pay is	\$480