




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, please contact the Fund Office at 1-818-846-1015 or 1-800-227-7863 or through our website, www.pwga.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 1-800-227-7863 to request a copy. There is a separate SBC for the PPO [Plan](#).

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$750 person / \$2,250 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive Care , LiveHealth online visit and primary care services through “The Industry Health Network ” (TIHN, Southern California only) are covered before you meet your deductible .	This plan covers some items and services even if you haven’t met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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?	Network Providers : \$4,500/individual (coinsurance only) Non-Network Providers : \$20,000/individual (coinsurance only) ACA Network Providers : \$8,700 /individual; \$17,400 /family (includes deductibles , coinsurance , copayment)	The out-of-pocket limit is the most you could pay in a year for covered services. In addition to having a Plan out-of-pocket limit for coinsurance , the Fund complies with the Affordable Care Act (ACA) annual out-of-pocket limit on in- network cost sharing for Plan Participants.
What is not included in the out-of-pocket limit?	Premium , balance-billed charges, provider discounts and health care expenses this Plan does not cover.	Even though you pay these expenses, they don’t count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. For The Industry Health Network (TIHN, Southern California only), call 1-800-876-8320. For the Blue Cross/Blue Card network at 1-800-810-BLUE (2583).	This plan uses a provider network . You will pay less if you use a provider in the plan's 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). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes. If you obtain services through TIHN (in Southern California only), you need a referral when seeing a specialist .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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	30% coinsurance (\$10 copay /visit through TIHN, deductible does not apply). LiveHealth online: \$20 copay /visit, deductible does not apply.	40% coinsurance	Copay for LiveHealth online visit will be waived if the online doctor refers the patient to the emergency room.
	Specialist visit	30% coinsurance (\$10 copay /visit through TIHN, deductible does not apply)	40% coinsurance	None
	Preventive care/screening/immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance (0% coinsurance through TIHN)	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance (0% coinsurance through TIHN)	40% coinsurance	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.pwga.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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pwga.org	Generic drugs	Not Covered	Not Covered	You must pay 100% of this service, even in-network. Certain ACA preventive care drugs (as required under health reform) may be covered with no cost sharing under the medical plan .
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	You must pay 100% of this service, even in-network.
	Specialty drugs	Not Covered	Not Covered	You must pay 100% of this service, even in-network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance (0% coinsurance through TIHN)	40% coinsurance	<ul style="list-style-type: none"> *Out-of-Network and Out-of-Area ambulatory surgery centers are limited to maximum payment of \$1,500. Some surgery services may require preauthorization review Some surgery services may require preauthorization review. Assistant surgeon fees are payable at 20% coinsurance of the surgeon's contracted or Allowed Charge.
	Physician/surgeon fees	30% coinsurance (No charge after \$100 copay /procedure through TIHN)	40% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance after \$50 ER copay /visit	40% coinsurance after \$50 ER copay /visit	<ul style="list-style-type: none"> Copay is waived if admitted; hospital admission copay applies Non-Network emergency room services may qualify for in-network coinsurance if the condition meets the definition of emergency care Professional/physician charges may be billed separately.
	Emergency medical transportation	Ground, Air or Sea: 30% coinsurance	Ground, Air or Sea: 40% coinsurance	
	Urgent care	30% coinsurance	40% coinsurance	None

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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 have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after \$100 copay /admission (No charge after \$100 copay /admission through TIHN)	40% coinsurance after \$100 copay /admission	Requires preauthorization review. Private room payable only if medically necessary or the hospital only has private rooms (payable at semi-private room rate).
	Physician/surgeon fees	30% coinsurance (No charge after \$100 copay /admission through TIHN)	40% coinsurance	\$100 copay applies to surgeon fees through TIHN.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and other outpatient services: 30% coinsurance LiveHealth online: \$10 copay /visit, deductible does not apply.	Office visits and other outpatient services: 40% coinsurance	Facility requires preauthorization review (includes Intensive Outpatient Programs and Partial Hospitalization).
	Inpatient services	30% coinsurance after \$100 copay /admission	40% coinsurance after \$100 copay /admission	Requires preauthorization review. Private room payable only if medically necessary or the hospital only has private rooms (payable at semi-private room rate).
If you are pregnant	Office visits	Prenatal care: No charge Office visits: 30% coinsurance	40% coinsurance	<ul style="list-style-type: none"> • Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	30% coinsurance (No charge after \$100 copay through TIHN)	40% coinsurance	<ul style="list-style-type: none"> • Delivery expenses are not covered for dependent children • Preauthorization is required if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section
	Childbirth/delivery facility services	30% coinsurance after \$100 copay /admission (No charge after \$100 copay /admission through TIHN)	40% coinsurance after \$100 copay /admission	<ul style="list-style-type: none"> • Private room payable only if medically necessary or the hospital only has private rooms (payable at semi-private room rate)

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.pwga.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)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Requires preauthorization review to avoid services not being covered.
	Rehabilitation services	Inpatient: 30% coinsurance after \$100 copay /admission (No charge after \$100 copay /admission through TIHN) Outpatient: 30% coinsurance	Inpatient: 40% coinsurance after \$100 copay /admission Outpatient: 40% coinsurance	Requires preauthorization review to avoid services not being covered.
	Habilitation services	30% coinsurance	40% coinsurance	<ul style="list-style-type: none"> Some services may require preauthorization review Outpatient physical therapy and occupational therapy are limited to maximum allowable charge of \$90/visit
	Skilled nursing care	30% coinsurance after \$100 copay /admission	40% coinsurance after \$100 copay /admission	Requires preauthorization review to avoid services not being covered.
	Durable medical equipment	30% coinsurance	40% coinsurance	Subject to medical necessity review.
	Hospice services	30% coinsurance	40% coinsurance	Requires preauthorization review to avoid services not being covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even <u>in-network</u> .

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.pwga.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](#).)

- Cosmetic surgery
- Dental care (adult, child)
- Experimental or Investigational procedures
- Infertility treatment (adult) under a separate fertility plan
- Long-term care
- Pharmacy Drugs
- Private duty nursing
- Routine eye care (adult, child)
- Wellness

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

- Acupuncture (for chronic pain up to \$60/visit)
- Chiropractic Care (up to \$60/visit)
- Hearing Aids (up to \$1,000 maximum/device)
- Non-emergency care when traveling outside the U.S.
- Routine foot care (for vascular impairment due to diabetes)
- Weight loss Programs (including bariatric surgery)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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 on how 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: Writers' Guild-Industry Health Fund at 1-818-846-1015 or 1-800-227-7863.

Does this plan provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 1-800-227-7863 (TTY: 1-818-526-3199).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-227-7863 (TTY: 1-818-526-3199).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-227-7863 (TTY: 1-818-526-3199).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-227-7863 (TTY: 1-818-526-3199).

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](#) \$750
- [Specialist coinsurance](#) 30%
- [Hospital \(facility\) coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$100
Coinsurance	\$3,400
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Peg would pay is	\$4,280

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist coinsurance](#) 30%
- [Hospital \(facility\) coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$0
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$4,400
The total Joe would pay is	\$1,755

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist coinsurance](#) 30%
- [Hospital \(facility\) coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$50
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$1,410