
 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](http://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.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$400</b> person / <b>\$1,200</b> family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<b>Yes.</b> <a href="#">Preventive Care</a> , LiveHealth online visit, In- <a href="#">network prescription drugs</a> and primary care services through “The Industry Health <a href="#">Network</a> ” (TIHN, Southern California only) are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven’t met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>No</b>	You don’t have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Network Providers</a> : \$1,000/individual ( <a href="#">coinsurance</a> only) <a href="#">Non-Network</a> Providers: \$20,000/individual ( <a href="#">coinsurance</a> only) ACA <a href="#">Network Providers</a> : <b>\$8,700</b> /individual; <b>\$17,400</b> /family (includes <a href="#">deductibles</a> , <a href="#">coinsurance</a> , <a href="#">copayments</a> )	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. In addition to having a <a href="#">Plan out-of-pocket limit</a> for <a href="#">coinsurance</a> , the Fund complies with the Affordable Care Act (ACA) annual <a href="#">out-of-pocket limit</a> on in- <a href="#">network</a> cost sharing for <a href="#">Plan</a> Participants.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premium</a> , <a href="#">balance-billed</a> charges, <a href="#">provider</a> discounts and health care expenses 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> .

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

 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-Area Provider	Non-Network (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	15% <a href="#">coinsurance</a> (\$10 <a href="#">copay</a> /visit through TIHN, <a href="#">deductible</a> does not apply). LiveHealth online: \$20 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply.	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Copay</a> for LiveHealth online visit will be waived if the online doctor refers the patient to the emergency room.
	<a href="#">Specialist</a> visit	15% <a href="#">coinsurance</a> (\$10 <a href="#">copay</a> /visit through TIHN, <a href="#">deductible</a> does not apply)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive, then check what your <a href="#">plan</a> will pay.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a> (0% <a href="#">coinsurance</a> through TIHN)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	15% <a href="#">coinsurance</a> (0% <a href="#">coinsurance</a> through TIHN)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.pwga.org](http://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-Area Provider	Non-Network (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	Retail \$10 <a href="#">copay</a> /Rx; Mail order \$20 <a href="#">copay</a> /Rx	You pay the pharmacy the full amount of your prescription and must submit a claim to Express Scripts. You'll receive a reimbursement of the highest dollar amount according to the <a href="#">plan</a> formula.	Non-Network (You will pay the most)	<ul style="list-style-type: none"> <li>• Retail covers up to a 30-day supply</li> <li>• Mail order covers up to a 90-day supply</li> <li>• <a href="#">Deductible</a> does not apply</li> <li>• * See SPD for list of over-the-counter generic drugs available at no cost at an In-<a href="#">Network</a> pharmacy with a prescription</li> <li>• Drugs on the ESI's drug exclusion list will not be covered by the <a href="#">Plan</a> without an advanced exception</li> <li>• Retail Hepatitis C drugs and Compound drugs require <a href="#">preauthorization</a> to avoid non-payment</li> <li>• No charge for ACA-required generic (or brand if the generic is medically inappropriate) preventive care drugs (such as contraceptives).</li> <li>• Mail order service is mandatory for maintenance medications through ESI or Smart90 program (Walgreens, Duane Reade, Happy Harry's)</li> </ul>
	Preferred brand drugs	Retail \$25 <a href="#">copay</a> /Rx; Mail order \$50 <a href="#">copay</a> /Rx			
	Non-preferred brand drugs	Retail \$50 <a href="#">copay</a> /Rx; Mail order \$100 <a href="#">copay</a> /Rx			
	<a href="#">Specialty drugs</a>	\$0 copay for <a href="#">specialty drugs</a> if you enroll in SaveonSP program  For <a href="#">specialty drugs</a> not covered by SaveonSP, same <a href="#">copays</a> as generic, preferred brand or non-preferred brand drugs.	Not covered.	<a href="#">Specialty drugs</a> must be ordered through Express Scripts Accredo.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a> (0% <a href="#">coinsurance</a> through TIHN)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<ul style="list-style-type: none"> <li>• <a href="#">Non-Network</a> and Out-of-Area ambulatory surgery centers are limited to maximum payment of \$1,500</li> <li>• Some surgery services may require <a href="#">preauthorization</a> review</li> <li>• Some surgery services may require <a href="#">preauthorization</a> review.</li> <li>• Assistant surgeon fees are payable at 20% <a href="#">coinsurance</a> of the surgeon's contracted or Allowed Charge.</li> </ul>
	Physician/surgeon fees	15% <a href="#">coinsurance</a> (No charge after \$100 <a href="#">copay</a> /procedure through TIHN)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	15% <a href="#">coinsurance</a> after \$50 ER <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a> after \$50 ER <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a> after \$50 ER <a href="#">copay</a> /visit	<ul style="list-style-type: none"> <li>• <a href="#">Copay</a> is waived if admitted; hospital admission <a href="#">copay</a> applies</li> <li>• <a href="#">Non-Network</a> and Out-of-Area emergency room services may qualify for in-network coinsurance if the condition meets the definition of emergency care</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.pwga.org](http://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-Area Provider	Non-Network (You will pay the most)	
					<ul style="list-style-type: none"> <li>Professional/physician charges may be billed separately.</li> </ul>
	<a href="#">Emergency medical transportation</a>	Ground: 20% <a href="#">coinsurance</a> Air or Sea: 15% <a href="#">coinsurance</a>	Ground or Sea: 20% <a href="#">coinsurance</a> Air: 20% <a href="#">coinsurance</a>	Ground or Sea: 20% <a href="#">coinsurance</a> Air: 40% <a href="#">coinsurance</a>	Air or Sea ambulance is subject to <a href="#">medical necessity</a> review and covered if the transport is to the nearest equipped facility.
	<a href="#">Urgent care</a>	15% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission (No charge after \$100 <a href="#">copay</a> /admission through TIHN)	20% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	40% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	Requires <a href="#">preauthorization</a> review. Private room payable only if <a href="#">medically necessary</a> or the hospital only has private rooms (payable at semi-private room rate).
	Physician/surgeon fees	15% <a href="#">coinsurance</a> (No charge after \$100 <a href="#">copay</a> /admission through TIHN)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> 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: 15% <a href="#">coinsurance</a> LiveHealth online: \$10 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply.	Office visits and other outpatient services: 20% <a href="#">coinsurance</a>	Office visits and other outpatient services: 40% <a href="#">coinsurance</a>	Facility requires <a href="#">preauthorization</a> review (includes Intensive Outpatient Programs and Partial <a href="#">Hospitalization</a> ).
	Inpatient services	15% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	20% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	40% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	Requires <a href="#">preauthorization</a> review. Private room payable only if <a href="#">medically necessary</a> 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: 15% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<ul style="list-style-type: none"> <li>Prenatal care (other than ACA-required preventive <a href="#">screenings</a>) is not covered for dependent children</li> <li>Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.pwga.org](http://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-Area Provider	Non-Network (You will pay the most)	
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a> (No charge after \$100 <a href="#">copay</a> /admission through TIHN)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<ul style="list-style-type: none"> <li>• Delivery expenses are not covered for dependent children</li> <li>• <a href="#">Preauthorization</a> is required if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section</li> <li>• Private room payable only if <a href="#">medically necessary</a> or the hospital only has private rooms (payable at semi-private room rate)</li> </ul>
	Childbirth/delivery facility services	15% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission (No charge after \$100 <a href="#">copay</a> /admission through TIHN)	20% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	40% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Requires <a href="#">preauthorization</a> review to avoid services not being covered.
	<a href="#">Rehabilitation services</a>	Inpatient: 15% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission (No charge after \$100 <a href="#">copay</a> /admission through TIHN) Outpatient: 15% <a href="#">coinsurance</a>	Inpatient: 20% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission Outpatient: 20% <a href="#">coinsurance</a>	Inpatient: 40% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission Outpatient: 40% <a href="#">coinsurance</a>	Requires <a href="#">preauthorization</a> review to avoid services not being covered.
	<a href="#">Habilitation services</a>	15% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<ul style="list-style-type: none"> <li>• Some services may require <a href="#">preauthorization</a> review</li> <li>• Outpatient physical therapy and occupational therapy are limited to maximum allowable charge of \$90/visit</li> </ul>
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	20% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	40% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /admission	Requires <a href="#">preauthorization</a> review to avoid services not being covered.
	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">medical necessity</a> review.
	<a href="#">Hospice services</a>	15% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Requires <a href="#">preauthorization</a> review to avoid services not being covered.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.pwga.org](http://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-Area Provider	Non-Network (You will pay the most)	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered	Vision benefits available through VSP Vision Care.
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	Dental benefits available through Delta Dental.

## 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) under a separate dental [plan](#)
- Experimental or Investigational procedures
- Infertility treatment (adult) under a separate fertility plan
- Long-term care
- Private duty nursing
- Routine eye care (adult, child) under a separate vision [plan](#)

### 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](http://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](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 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](#) **\$400**
- [Specialist coinsurance](#) **15%**
- [Hospital \(facility\) coinsurance](#) **15%**
- Other [coinsurance](#) **15%**

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$110
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$1,530</b>

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

- The plan's overall [deductible](#) **\$400**
- [Specialist coinsurance](#) **15%**
- [Hospital \(facility\) coinsurance](#) **15%**
- Other [coinsurance](#) **15%**

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$880
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$160
<b>The total Joe would pay is</b>	<b>\$1,510</b>

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

- The [plan's](#) overall [deductible](#) **\$400**
- [Specialist coinsurance](#) **15%**
- [Hospital \(facility\) coinsurance](#) **15%**
- Other [coinsurance](#) **15%**

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$60
Coinsurance	\$380
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$840</b>