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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400 person / $1,200 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, In-network prescription drugs 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: $1,000/individual (coinsurance only) Non-Network Providers: $20,000/individual (coinsurance only) ACA Network Providers: $7,350/individual; $14,700/family (includes deductibles, coinsurance, copayments)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. 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-Area Provider	Non-Network (You will pay the most)	
Primary care visit to treat an injury or illness	Primary care visit to treat an injury or illness	15% coinsurance ($10 copay/visit through TIHN, deductible does not apply). LiveHealth online: $20 copay/visit, deductible does not apply.	20% coinsurance	40% coinsurance	Copay for LiveHealth online visit will be waived if the online doctor refers the patient to the emergency room.
	Specialist visit	15% coinsurance ($10 copay/visit through TIHN, deductible does not apply)	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	40% coinsurance	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)	15% coinsurance (No charge through TIHN)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance (No charge through TIHN)	20% coinsurance	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-Area Provider	Non-Network (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.express-scripts.com	Generic drugs	Retail $10 copay/Rx; Mail order $20 copay/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 plan formula.		• Deductible does not apply • * See SPD for list of over-the-counter generic drugs available at no cost at an In-Network pharmacy with a prescription • Drugs on the ESI's drug exclusion list will not be covered by the Plan without an advanced exception • Retail Hepatitis C drugs and Compound drugs require preauthorization to avoid non-payment • No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate) • Using the mail order service is mandatory for maintenance medications (alternatively, Smart 90)
	Preferred brand drugs	Retail $25 copay/Rx; Mail order $50 copay/Rx			
	Non-preferred brand drugs	Retail $50 copay/Rx; Mail order $100 copay/Rx			
	Specialty drugs	Same copays as generic, preferred brand or non-preferred brand drugs.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	20% coinsurance	40% coinsurance	*Out-of-Network and Out-of-Area ambulatory surgery centers are limited to maximum payment of $1500.
	Physician/surgeon fees	15% coinsurance (No charge after $100 copay through TIHN)	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	15% coinsurance after $50 ER copay	20% coinsurance after $50 ER copay	40% coinsurance after $50 ER copay	If services are rendered at a network facility by a network physician, you pay 15% coinsurance plus balance billing for Non-Network or Out-of-Area anesthesiologist, radiologist, pathologist as defined in the SPD. Professional/physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Air or Sea ambulance	15% coinsurance	20% coinsurance	40% coinsurance	Air or Sea ambulance is subject to medical necessity review and covered if the transport is to the nearest equipped facility.
	Urgent care	15% coinsurance	20% coinsurance	40% coinsurance	None

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 have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after $100 copay/admission (No charge after $100 copay/admission through TIHN)	20% 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).
	Physician/surgeon fees	15% coinsurance (No charge after $100 copay through TIHN)	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and other outpatient services: 15% coinsurance LiveHealth online: $10 copay/visit, deductible does not apply.	Office visits and other outpatient services: 20% coinsurance	Office visits and other outpatient services: 40% coinsurance	Facility requires preauthorization review (includes Intensive Outpatient Programs and Partial Hospitalization).
	Inpatient services	15% coinsurance after $100 copay/admission	20% 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: 15% coinsurance	20% coinsurance	40% coinsurance	• 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	15% coinsurance (No charge after $100 copay through TIHN)	20% coinsurance	40% coinsurance	• 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 • Private room payable only if medically necessary or the hospital only has private rooms (payable at semi-private room rate)
	Childbirth/delivery facility services	15% coinsurance after $100 copay/admission (No charge after $100 copay/admission	20% coinsurance after $100 copay/admission	40% coinsurance after $100 copay/admission	

* 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-Area Provider	Non-Network (You will pay the most)	
		through TIHN)			
If you need help recovering or have other special health needs	Home health care	15% coinsurance	20% coinsurance	40% coinsurance	Requires preauthorization review to avoid services not being covered.
	Rehabilitation services	Inpatient: 15% coinsurance after $100 copay/admission (No charge after $100 copay/admission through TIHN) Outpatient: 15% coinsurance	Inpatient: 20% coinsurance after $100 copay/admission Outpatient: 20% coinsurance	Inpatient: 40% coinsurance after $100 copay/admission Outpatient: 40% coinsurance	Requires preauthorization review to avoid services not being covered.
	Habilitation services	15% coinsurance	20% coinsurance	40% coinsurance	• Requires preauthorization review to avoid services not being covered • Outpatient physical therapy and occupational therapy are limited to maximum allowable charge of $60/visit
	Skilled nursing care	15% coinsurance after $100 copay/admission	20% coinsurance after $100 copay/admission	40% coinsurance after $100 copay/admission	Requires preauthorization review to avoid services not being covered.
	Durable medical equipment	15% coinsurance	20% coinsurance	40% coinsurance	Subject to medical necessity review.
	Hospice services	15% coinsurance	20% coinsurance	40% coinsurance	Requires preauthorization review to avoid a services not being covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	If you elect vision benefits, they will be through a separate vision plan (with VSP).
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	If you elect dental benefits, they will be through a separate dental plan (with 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
- 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

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 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

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 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, kwiijigo 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.

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

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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments (hospital admission)	$100
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$1,500

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)*

Total Example Cost	$4,100

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments (prescription drugs)	$80
Coinsurance	$555
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,035

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)*

Total Example Cost	$9,200

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments (emergency room)	$50
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,450

The plan would be responsible for the other costs of these EXAMPLE covered services.