




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, go to [www.centralpateamsters.com](http://www.centralpateamsters.com) or call 1-800-422-8330. 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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-422-8330 (PA) or 1-800-331-0420 (USA) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$500 person/ \$1,500 family	You must pay all the costs up to the <a href="#">deductible</a> amount for non-participating <a href="#">providers</a> 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 family <a href="#">deductible</a> is met.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, Preventive Care and services for participating providers.	This <a href="#">plan</a> covers some items and Preventive services even if you haven't met the <a href="#">deductible</a> amount. A <a href="#">copayment</a> may apply. 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>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,000 person/ \$6,000 family	The <b>out-of-pocket limit</b> for services is the most you could pay during in a year for covered services. If you have other family members in this plan, they have to meet their own out of pocket limits until the family <b>out-of-pocket limit</b> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Copayments, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, visit <a href="http://www.centralpateamsters.com">www.centralpateamsters.com</a> or call Meritain Health 1-800-343-3140	This plan 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="#">providers</a> charge and what your plan 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> ?	No.	You do not need a referral to see a <a href="#">specialist</a> . You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</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-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 copay/ visit	\$40 copay/ visit plus amt over UCR	-----none-----
	<a href="#">Specialist</a> visit	\$40 copay/ visit	\$65 copay/ visit plus amt over UCR	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	\$30 copay/visit plus amt over UCR	-----none-----
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance	20% coinsurance plus amt over UCR	Preauthorization is require on certain diagnostic services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance plus amt over UCR	-----none-----
<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.centralpateamsters.com">www.centralpateamsters.com</a>	Generic drugs	\$5 copay/ Rx retail; \$15 copay/ Rx mail order	Amount greater than Fund cost plus copay	Covers up to a 34 day supply (retail Rx); 35-90 day supply (mail order Rx)
	Preferred brand drugs	\$15 copay/Rx retail; \$30 copay/Rx mail order	Amount greater than Fund cost plus copay	Covers up to a 34 day supply (retail Rx); 35-90 day supply (mail order Rx)
	Non-preferred brand drugs	\$30 copay/Rx retail; \$60 copay/Rx mail order	Amount greater than Fund cost plus copay	Covers up to a 34 day supply (retail Rx); 35-90 day supply (mail order Rx)
	<a href="#">Specialty drugs</a>	\$150 copay/Rx retail; \$300 copay/Rx mail order	Amount greater than Fund cost plus copay	Covers up to a 34 day supply (retail Rx); 35-90 day supply (mail order Rx)
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance plus amt over UCR	Preauthorization is require for certain surgical services
	Physician/surgeon fees	20% coinsurance	20% coinsurance plus amt over UCR	Preauthorization is require for certain surgical services
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 copay	\$100 copay	-----none-----
	<a href="#">Emergency medical transportation</a>	\$100 copay	\$100 copay	-----none-----
	<a href="#">Urgent care</a>	\$30 copay	\$40 copay plus amt. over UCR	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance plus amt over UCR	Preauthorization is required
	Physician/surgeon fees	20% coinsurance	20% coinsurance plus amt over UCR	Preauthorization is required

[\* For more information about limitations and exceptions, see the plan or policy document at [www.centralpateamsters.com](http://www.centralpateamsters.com).]

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Not Covered	Not Covered	Not Covered
	Inpatient services	Not Covered	Not Covered	Not Covered
<b>If you are pregnant</b>	Office visits	\$30 copay for initial office visit	\$40 copay plus amt. over UCR	No coverage for dependent children
	Childbirth/delivery professional services	No charge	20% coinsurance plus balances over UCR	Preauthorization is required if your admit exceeds 48 hours for vaginal delivery or 96 hours for cesarean delivery. No coverage for dependent children.
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance plus amt over UCR	Preauthorization is required if your admit exceeds 48 hours for vaginal delivery or 96 hours for cesarean delivery. No coverage for dependent children.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$30 copay for doctor services	\$40 copay for doctor services plus any balance over UCR	-----none-----
	<a href="#">Rehabilitation services</a>	\$30 copay	\$40 copay plus any balance over UCR	-----none-----
	<a href="#">Habilitation services</a>	\$30 copay	\$40 copay plus any balance over UCR	-----none-----
	<a href="#">Skilled nursing care</a>	20% coinsurance up to 240 hrs; after 240 hrs 50% coinsurance	20% coinsurance up to 240 hrs; after 240 hrs 50% coinsurance	-----none-----
	<a href="#">Durable medical equipment</a>	20% coinsurance	20% coinsurance plus amt over UCR	-----none-----
	<a href="#">Hospice services</a>	20% coinsurance	20% coinsurance plus amt over UCR	Preauthorization is required
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

[\* For more information about limitations and exceptions, see the plan or policy document at [www.centralpateamsters.com](http://www.centralpateamsters.com).]

## 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"><li>• Cosmetic Surgery</li><li>• Chiropractic Care</li><li>• Dental Care</li></ul> | <ul style="list-style-type: none"><li>• Infertility Treatment</li><li>• Hearing Aids</li><li>• Routine Eye Care</li></ul> | <ul style="list-style-type: none"><li>• Long Term Care</li><li>• Mental/Behavioral Health &amp; Substance Abuse Services</li></ul> |
|--|---|--|

### 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"><li>• Acupuncture</li><li>• Bariatric Surgery</li></ul> | <ul style="list-style-type: none"><li>• Non-Emergency Care when Traveling Outside of the United States</li></ul> | <ul style="list-style-type: none"><li>• Private Duty Nursing</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</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: [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](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: Plan Administrator at 1-800-422-8330 (PA) or 1-800-331-0420 (USA).

### 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 1-800-422-8330 (PA) or 1-800-331-0420 (USA).]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-422-8330 (PA) or 1-800-331-0420 (USA).]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-422-8330 (PA) or 1-800-331-0420 (USA).]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-422-8330 (PA) or 1-800-331-0420 (USA).]

—————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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> [copayment]	\$0
■ Hospital (facility) [coinsurance]	0%
■ Other [coinsurance]	20%

#### 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>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$20
Coinsurance	\$2,387
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,967</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> [copayment]	\$80
■ Hospital (facility) [coinsurance]	20%
■ Other [coinsurance]	20%

#### 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>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$710
Coinsurance	\$154
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,419</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$430
■ <a href="#">Specialist</a> [copayment]	\$80
■ Hospital (facility) [coinsurance]	0%
■ Other [coinsurance]	20%

#### 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>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$430
Copayments	\$270
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>