



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> ?	\$1,000 person/ \$2,000 family <u>participating providers</u> ; \$3,000 person/ \$6,000 family <u>non-participating providers</u>	You must pay all the costs up to the <u>deductible</u> amount for non-participating <u>providers</u> 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 <u>deductible</u> until the family <u>deductible</u> 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 <u>deductible</u> amount. A <u>copayment</u> may apply. See a list of covered <u>preventive services</u> 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> ?	\$2,000 person/ \$4,000 family for <u>participating providers</u> ; Unlimited for <u>non-participating providers</u>	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, <u>premiums</u> , <u>balance-billing</u> 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 <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <a href="#">plan's network</a> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>providers</u> charge and what your plan pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services such as lab work. Check with you <u>provider</u> 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 <u>specialist</u> . You can see the <u>specialist</u> 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)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$20 copay/ visit	\$30 copay/ visit plus amt over UCR	-----none-----
	<a href="#">Specialist</a> visit	\$30 copay/ visit	\$55 copay/ visit plus amt over UCR	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	\$30 copay/visit plus amt over UCR	-----none-----
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance	30% coinsurance plus amt over UCR	Preauthorization is require on certain diagnostic services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance plus amt over UCR	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.centralpateamsters.com">www.centralpateamsters.com</a>	Generic drugs	\$10 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)
	Preferred brand drugs	\$20 copay/Rx retail; \$40 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	\$50 copay/Rx retail; \$100 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)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance plus amt over UCR	Preauthorization is require for certain surgical services
	Physician/surgeon fees	20% coinsurance	30% coinsurance plus amt over UCR	Preauthorization is require for certain surgical services
If you need immediate medical attention	<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>	\$20 copay	\$30 copay plus amt. over UCR	-----none-----

[\* 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 have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance plus amt over UCR	Preauthorization is required
	Physician/surgeon fees	20% coinsurance	30% coinsurance plus amt over UCR	Preauthorization is required
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 copay	\$30 copay plus any balance over UCR	-----none-----
	Inpatient services	20% coinsurance	30% coinsurance plus amt over UCR	-----none-----
<b>If you are pregnant</b>	Office visits	\$20 copay for initial office visit	\$30 copay plus amt. over UCR	No coverage for dependent children.
	Childbirth/delivery professional services	No charge	30% 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	30% 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>	\$20 copay for doctor services	\$30 copay for doctor services plus any balance over UCR	-----none-----
	<a href="#">Rehabilitation services</a>	\$10 copay	\$30 copay plus any balance over UCR	3 therapy services per day, 24 visits max
	<a href="#">Habilitation services</a>	\$10 copay	\$30 copay plus any balance over UCR	3 therapy services per day, 24 visits max
	<a href="#">Skilled nursing care</a>	20% coinsurance up to 240 hrs; after 240 hrs 50% coinsurance	30% coinsurance up to 240 hrs; after 240 hrs 50% coinsurance	-----none-----
	<a href="#">Durable medical equipment</a>	20% coinsurance	30% coinsurance plus any balance over UCR	-----none-----
	<a href="#">Hospice services</a>	20% coinsurance	30% coinsurance plus amt over UCR	-----none-----

[\* 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)	
If your child needs dental or eye care	Children's eye exam	No Charge	Any charges greater than \$45	One exam every two years for children age 19 and over; one exam per year for children less than 19 years
	Children's glasses	No Charge	Any charges greater than \$75	Two pair of glasses or one pair of glasses and contacts every two years for children age 19 and over; one pair of glasses or contacts per year for children age 18 and under.
	Children's dental check-up	20% coinsurance	20% coinsurance plus amt over UCR	Children over age 19 will have a \$800 annual dental limit

**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
- Infertility Treatment
- Long Term Care

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Non-Emergency Care when Traveling Outside of the United States
- Hearing Aids
- Dental Care (Adult)
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs
- Routine Eye Care

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

**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 contact the plan at 1-800-422-8330 (PA) or 1-800-331-0420 (USA). You may also contact the 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: Plan Administrator at 1-800-422-8330 (PA) or 1-800-331-0420 (USA).].

**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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].][Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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](#) \$1,000
- [Specialist \[cost sharing\]](#) \$0
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$3,081</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$60
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$122
<a href="#">Copayments</a>	\$972
<a href="#">Coinsurance</a>	\$104
<i>What isn't covered</i>	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$1,220</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$60
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$6230
<a href="#">Copayments</a>	\$310
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$933</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.