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 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 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 deductible?	$500 person/ $1,000 family participating providers; $3,000 person/ $6,000 family non-participating providers	You must pay all the costs up to the deductible amount for non-participating providers 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 family deductible is met.
Are there services covered before you meet your deductible?	Yes, Preventive Care and services for participating providers.	This plan covers some items and Preventive services even if you haven't met the deductible amount. A copayment may apply. 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$1,000 person/ $2,000 family for participating providers; Unlimited for non-participating providers	The **out-of-pocket limit** 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 **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Copayments, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes, visit www.centralpateamsters.com or call Meritain Health 1-800-343-3140	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 providers 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 you provider before you get services.
Do you need a referral to see a specialist?	No.	You do not need a referral to see a specialist. You can see the specialist you choose without permission from this plan.

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	$20 copay/ visit	$30 copay/ visit plus amt over UCR	----------none----------
	Specialist visit	$30 copay/ visit	$55 copay/ visit plus amt over UCR	----------none----------
	Preventive care/screening/ immunization	No charge	$30 copay/visit plus amt over UCR	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance plus amt over UCR	Preauthorization is require on certain diagnostic services.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance plus amt over UCR	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.centralpateamsters.com	Generic drugs	$0 copay/ Rx retail or mail order	Amount greater than Fund cost plus copay	Covers up to a 90 day supply retail or 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	$40 copay/Rx retail; $80 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)
	Specialty drugs	$150 copay/Rx retail; $300 copay/Rx mail order	Amount greater than Fund cost plus copay	Covers up to a 30 day supply (retail Rx); up to 90 day supply (mail order Rx)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance plus amt over UCR	Preauthorization is require for certain surgical services
	Physician/surgeon fees	10% coinsurance	30% coinsurance plus amt over UCR	Preauthorization is require for certain surgical services
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	----------none----------
	Emergency medical transportation	$100 copay	$100 copay	----------none----------
	Urgent care	$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.]

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)	$100 copay	$100 copay; 30% coinsurance	Preauthorization is required
	Physician/surgeon fees	10% coinsurance	30% coinsurance plus amt over UCR	Preauthorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay	$30 copay plus any balance over UCR	----------none----------
	Inpatient services	10% coinsurance	30% coinsurance plus amt over UCR	----------none----------
If you are pregnant	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	10% coinsurance	30% coinsurance plus any balance 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.
If you need help recovering or have other special health needs	Home health care	$20 copay for doctor services	$30 copay for doctor services plus any balance over UCR	----------none----------
	Rehabilitation services	$20 copay	$30 copay plus any balance over UCR	3 therapy services per day, 24 visits max
	Habilitation services	$20 copay	$30 copay plus any balance over UCR	3 therapy services per day, 24 visits max
	Skilled nursing care	10% coinsurance up to 240 hrs; after 240 hrs 50% coinsurance	30% coinsurance up to 240 hrs; after 240 hrs 50% coinsurance	----------none----------
	Durable medical equipment	10% coinsurance	30% coinsurance plus any balance over UCR	----------none----------
	Hospice services	10% coinsurance	30% coinsurance plus any balance over UCR	----------none----------

[* For more information about limitations and exceptions, see the plan or policy document at 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 any balance 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.]

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, 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: 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, kwiijigo holne' [insert telephone number].]

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	**$500**
Specialist *[cost sharing]*	**$0**
Hospital (facility) *[cost sharing]*	**10%**
Other *[cost sharing]*	**10%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

The plan's overall deductible	**$500**
Specialist *[cost sharing]*	**$60**
Hospital (facility) *[cost sharing]*	**10%**
Other *[cost sharing]*	**10%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$660
Coinsurance	$81
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,241**

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

The plan's overall deductible	**$500**
Specialist *[cost sharing]*	**$60**
Hospital (facility) *[cost sharing]*	**10%**
Other *[cost sharing]*	**10%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$430
Copayments	$190
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$620**

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