



MEBA Benefit Plans

Safeguarding MEBA Members and Families

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www.mebaplans.org

IMPORTANT NOTICE

To: Active Participants in the MEBA Medical and Benefits Plan

From: Patricia Kelly, Executive Director

Re: Summary of Benefits Coverage

Enclosed is a “Summary of Benefits and Coverage (“SBC”), which the federal Government requires us to provide under Health Care Reform. The SBC does not describe all of your benefits under the MEBA Medical and Benefits Plan (the MEBA Medical Plan) and does not replace the MEBA Medical Plan’s Rules and Regulations. The Rules and Regulations contain the complete explanation of your benefits under the MEBA Medical Plan. If there is any inconsistency between the enclosed SBC and the Rules and Regulations, the terms of the Rules and Regulations shall prevail.

We want to emphasize that much of the language contained in the SBC is mandated by the federal Government. Therefore, there are several terms in the SBC that are not applicable to the MEBA Medical Plan, but which we had no choice but to include because the regulations governing the SBC do not allow us to deviate from the mandated language.


If you have any questions about the enclosed SBC, or your coverage under the MEBA Medical Plan, please call the Plan Office at (410) 547-9111.

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.mebaplans.org or call 1-800-811-6322. 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 1-800-811-6322 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$250 person/\$500 family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. Certain preventive services are covered.	Certain preventive services are covered without <u>cost-sharing</u> . See the Common Medical Events chart starting on page 2 for a list of the specific services this plan covers without <u>cost-sharing</u> .
Are there other deductibles for specific services?	Yes, \$250 person/\$500 family deductible for out-of-network inpatient hospital facility and ambulatory surgical center. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before the plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	Yes, \$3,500 Covered Medical Expenses \$1,500 Prescription Drug Expenses.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services.
What is not included in the out-of-pocket limit ?	Premiums, balanced-billed charges, health care this plan does not cover, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider ?	Yes. Call (800) 810-2583 or go online to www.bcbs.com for a list of <u>network providers</u> .	This plan uses a provider <u>network</u> . You will pay less if you use a provider in the plan's <u>network</u> . 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 provider's charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network</u> provider might use an <u>out-of-network provider</u> for some services (such as lab work).

Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .
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 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 per visit co-pay , plus 20% coinsurance	40% coinsurance	None*
	Specialist visit	\$20 per visit, plus 20% coinsurance	40% coinsurance	None*
	Preventive care/screening/ Immunization	<p>Preventive care: Adult - not covered.</p> <p>Preventive care: Children under 19 years of age – immunizations no charge.</p> <p>Immunizations: Limited to the CDC recommended guidelines adults 19 and older for no charge.*</p>	<p>Preventive care: Adult - not covered.</p> <p>Preventive care: Children under 19 years of age – immunizations no charge.</p>	<p>Preventive care/screening: no charge for one exam per year when performed at MEBA Diagnostic Center, approved alternate clinic, or in-network provider.</p> <p>Mammogram: for women no charge for one baseline mammogram age 35-39, and one annual mammogram age 40 and over.*</p> <p>GYN: no charge for one annual exam and related tests.*</p> <p>Colonoscopy: one routine colonoscopy once every 5 years age 45 or over.*</p> <p>Colorectal cancer screening test: one screening once every 3 yrs age 50 or over for asymptomatic patients.</p> <p>Annual Flu Shot: no charge for one annual influenza vaccine.*</p> <p>Adult immunizations covered in network only.</p> <p>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what the plan will pay for.</p>
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None*

[* For more information about limitations and exceptions, see the plan or policy document at www.mebaplans.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-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None*
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	20% coinsurance	20% coinsurance	Plan pays 100% costs of certain over-the-counter medications if prescribed by your doctor.* Please call 1-800-811-6322 to obtain a list of these medications. Generally, limited up to 180 days of maintenance drugs and 34 days of acute medications.*
	Preferred brand drugs	20% coinsurance , plus the difference in cost between the brand-name drug and an equivalent generic drug.	20% coinsurance , plus the difference in cost between the brand-name drug and an equivalent generic drug.	
	Non-preferred brand drugs	20% coinsurance , plus the difference in cost between the brand-name drug and an equivalent generic drug.	20% coinsurance , plus the difference in cost between the brand-name drug and an equivalent generic drug.	
	Specialty drugs	20% coinsurance , plus the difference in cost between the brand-name drug and an equivalent generic drug*	20% coinsurance , plus the difference in cost between the brand-name drug and an equivalent generic drug*	Certain specialty prescription drugs, as determined from time to time by the Trustees, provided prior authorization is obtained.*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance , after deductible has been met	All outpatient surgery must be pre-certified in order to be covered.*
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None*
	Emergency room care	\$20 per visit co-pay , plus 20% coinsurance	40% coinsurance	None*

[* For more information about limitations and exceptions, see the plan or policy document at www.mebaplans.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-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	40% coinsurance	None*
	Urgent care	\$20 per visit co-pay , plus 20% coinsurance	40% coinsurance	None*
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance after deductible has been met	All hospital admissions must be pre-certified. Length of stay that exceeds certification is not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None*
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	30% coinsurance	Mental/Behavioral health - Limited to a maximum of 100 visits per 36 consecutive month period.* Substance Abuse – No charge.
	Inpatient services	10% coinsurance	40% coinsurance	Mental Behavioral health - Limited to 3 inpatient days per calendar year and amounts exceeding annual out-of-pocket maximum.* Substance Abuse: No charge. Residential room charges not covered* All hospital admissions must be pre-certified.
If you are pregnant	Office visits	\$20 per visit co-payment, plus 20% coinsurance	40% coinsurance	Not covered for dependent children.*
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Not covered for dependent children.*
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance after deductible has been met	All hospital admissions must be pre-certified. Length of stay that exceeds certification is not covered. Not covered for dependent children.*

[* For more information about limitations and exceptions, see the plan or policy document at www.mebaplans.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-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	\$20 per visit copay , plus 20% coinsurance	40% coinsurance	Home Health aides not covered.*
	Rehabilitation services	\$20 per visit, plus 20% coinsurance	40% coinsurance	Chiropractor and physical therapy visits limited to a combined 40 visits per person per 24-month period. *
	Habilitation services	<u>\$20 per visit copay, plus 20% coinsurance</u>	40% coinsurance	Chiropractor and physical therapy visits limited to a combined 40 visits per person per 24-month period. *
	Skilled nursing care	<u>\$20 per visit co-pay, plus 20% coinsurance</u>	40% coinsurance	Limited to first 30 days after hospitalization within a 12 month period for skilled nursing
	Durable medical equipment	20% coinsurance	40% coinsurance	None*
	Hospice services	20% coinsurance	40% coinsurance	Coverage is provided only for those who are terminally ill with cancer. *
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Coverage for children under age 19 is limited to one exam and one pair of glasses or contacts per calendar year up to the usual, customary and reasonable charge.* Coverage for children age 19 and over is limited to \$180 per calendar year; however, the balance may be carried over two calendar years, for up to a maximum three-year benefit of \$540.*
	Children's glasses	No charge	No charge	Coverage for children under age 19 is limited to one exam and one pair of glasses or contacts per calendar year up to the usual, customary and reasonable charge.* Coverage for children age 19 and over is limited to \$180 per calendar year; however, the balance may be carried over two calendar years, for up to a maximum three-year benefit of \$540.*

[* For more information about limitations and exceptions, see the plan or policy document at www.mebaplans.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-Network Provider (You will pay the most)	
	Dental check-up	No charge	No charge	\$100 individual/\$300 family deductible for all other covered services. Coverage is subject to a \$2,000 annual maximum.

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
- Weight loss program
- Long term care
- Private-duty nursing (except in connection with hospice care, home health care of step down units)

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

- Acupuncture*
- Bariatric surgery (for Active employees only)*
- Chiropractic care*
- Dental care (Adult)*
- Hearing aids*
- Infertility treatment*
- Non-emergency care when traveling outside the U.S.*
- Routine eye care (Adult)*
- Routine foot care*

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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: MEBA Medical & Benefits Plan 1-800-811-6322 or, www.mebaplans.org, or the Department of Labor, Employee Benefits Security Administration, at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> and <https://www.cms.gov/cciio/resources/consumer-assistance-grants>.

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

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 [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, kwijjigo 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](#) \$0
- [Specialist copayment](#) \$20
- [Hospital \(facility\) coinsurance](#) 10%
- [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*)

Total Example Cost	\$7,540
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$1,140
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Peg would pay is	\$1,140

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- [Hospital \(facility\) coinsurance sharing\]](#) 10%
- [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*)

Total Example Cost	\$5,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$20
Coinsurance	\$996
<i>What isn't covered</i>	
Limits or exclusions	\$300
The total Joe would pay is	\$1,316

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

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

- The plan's overall deductible \$0
- Specialist copay \$20
- Hospital (facility) coinsurance 10%
- 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*)

Total Example Cost	\$1,450
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$180
Coinsurance	\$254
<i>What isn't covered</i>	
Limits or exclusions	\$
The total Mia would pay is	\$434