**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,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 | 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. See the Common Medical Events chart below 2 for your costs for services this plan covers |
| **Are there services covered before you meet your deductible?** | No. | You will have to meet the **deductible** before the **plan** pays for any services. |
| **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?** | Yes, $ 3,500**,** if non-Medicare Eligible**.**<br>If Medicare Eligible, none. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for covered services. |
| **What is not included in The out-of-pocket limit?** | Amounts equal to Medicare's annual Part A and Part B deductibles and coinsurance. Premiums, balanced-billed charges. | 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. Call (800)810-2583 for a list of **network providers**. | 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). |

| | | |
|---|---|---|
| **Do you need a referral to see a specialist?** | No. | 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 | 40% **coinsurance** after **deductible** is met | 40% **coinsurance** after **deductible** is met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| | Specialist visit | 40% coinsurance after deductible is met | 40% **coinsurance** after **deductible** is met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| | Preventive care/screening/ immunization | **Preventive care:** Adult - not covered.<br><br>**Preventive care:** Children under 19 years of age – immunizations no charge.<br><br>**Immunizations:** Limited to the CDC recommended guidelines adults 19 and older for no charge.* | **Preventive care:** Adult - not covered.<br><br>**Preventive care:** Children under 19 years of age – immunizations no charge. | **Preventive care/screening:** no charge for one exam per year when performed at MEBA Diagnostic Center or approved alternative clinic.*<br>**Mammogram**: for women no charge for one baseline mammogram age 35-39, and one annual mammogram age 40 and over.*<br>**GYN**: no charge for one annual exam and related tests.*<br>**Colonoscopy**: one routine colonoscopy once every 5 years age 50 or over.*<br>**Colorectal cancer screening test:** one colorectal cancer screening once every 3 years age 50 or over for asymptomatic patients.<br>**Annual Flu Shot:** no charge for one annual influenza vaccine.*<br><br>Adult immunizations covered in network only. |

[* 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) | |
| | | | | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 40% **coinsurance** after **deductible** is met | 40% **coinsurance** after **deductible** is met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| | Imaging (CT/PET scans, MRIs) | 40% **coinsurance** after deductible is met | 40% **coinsurance** after **deductible** is met | If non-Medicare eligible, deductible and coinsurance amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.mebaplans.org | Generic drugs | Not covered | Not covered | None |
| | Preferred brand drugs | Not covered | Not covered | None |
| | Non-preferred brand drugs | Not covered | Not covered | None |
| | Specialty drugs | Not covered | Not covered | None |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | All outpatient surgery must be **pre-certified** in order to be covered. If non-Medicare eligible, deductible and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| | Physician/surgeon fees | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| **If you need immediate medical attention** | Emergency room care | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are |

[* 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) | |
| | | | | excluded from allowed charges. If Medicare eligible, not covered.* |
| | Emergency medical transportation | 40% **coinsurance** after **deductible** has been met | 40% coinsurance after deductible has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| | Urgent care | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance after deductible** has been met | All hospital admissions must be **pre-certified**. Length of stay that exceeds certification is not covered. If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| | Physician/surgeon fees | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |

[* 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 mental health, behavioral health, or substance abuse services** | Outpatient services | 50% **coinsurance** after **deductible** has been met | 50% **coinsurance** after **deductible** has been met | Mental/Behavioral health - Limited to a maximum of 100 visits per 36 consecutive month period.* Substance Abuse: no coverage.<br><br>If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| | Inpatient services | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | Mental/Behavioral health - Limited to 3 days per calendar year, up to additional 18 days if certain criteria is met. If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.*<br>All hospital admissions must be pre-certified. |
| **If you are pregnant** | Office visits | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. Not covered for dependent children. If Medicare eligible, not covered.* |
| | Childbirth/delivery professional services | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. Not covered for dependent children. If Medicare eligible, not covered.* |
| | Childbirth/delivery facility services | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | All hospital admissions must be **pre-certified**. Length of stay that exceeds certification is not covered. If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. Not |

| 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) | |
| | | | | covered for dependent children. If Medicare eligible, not covered.* |
| **If you need help recovering or have other special health needs** | Home health care | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. Home Health Aides not covered. If Medicare eligible, not covered.* |
| | Rehabilitation services | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | Chiropractor and physical therapy visits limited to a combined 40 visits per person per 24 month period. If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| | Habilitation services | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | Chiropractor and physical therapy visits limited to a combined 40 visits per person per 24 month period. If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |
| | Skilled nursing care | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. Coverage is limited to first 30 days after hospitalization within 12 month period for skilled nursing facility. Home visits must be by RN or LPN. If Medicare eligible, not covered.* |
| | Durable medical equipment | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. If Medicare eligible, not covered.* |

[* 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) | |
| | Hospice services | 40% **coinsurance** after **deductible** has been met | 40% **coinsurance** after **deductible** has been met | If non-Medicare eligible, **deductible** and **coinsurance** amounts under Medicare are excluded from allowed charges. Coverage provided only for those who are terminally ill with cancer. If Medicare eligible, not covered.* |
| **If your child needs dental or eye care** | Children's eye exam, glasses, contacts | 20% **coinsurance** | 20% **coinsurance** | 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 limited to $120 per calendar year; however; the balance may be carried over two calendar years, for up to a maximum three-year benefit of $360.* |
| | Children's glasses | 20% **coinsurance** | 20% **coinsurance** | 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 limited to $120 per calendar year; however; the balance may be carried over two calendar years, for up to a maximum three-year benefit of $360.* |
| | 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.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Long-term care
- Substance use disorder outpatient services
- Weight loss programs

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

- Non-emergency care when traveling outside the U.S.*
- Chiropractor care*
- Hearing aids*
- Infertility treatment*
- Routine eye care (Adult)*
- Routine foot care*
- Dental care (Adult)*

**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.

**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].]

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

[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** **$250**
- **Specialist** ***[cost sharing]*** **$20**
- **Hospital (facility)** ***[cost sharing]*** **40%**
- **Other** ***[cost sharing]*** **40%**

**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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $0 |
| Coinsurance | $3790 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Peg would pay is** | **$4,040** |

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

- **The plan's overall deductible** **$250**
- **Specialist** ***[cost sharing]*** **$20**
- **Hospital (facility)** ***[cost sharing]*** **40%**
- **Other** ***[cost sharing]*** **40%**

**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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $ |
| Copayments | $20 |
| Coinsurance | $2797 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Joe would pay is** | **$2,817** |

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** **$250**
- **Specialist** ***[cost sharing]*** **$20**
- **Hospital (facility)** ***[cost sharing]*** **40%**
- **Other** ***[cost sharing]*** **40%**

**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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $180 |
| Coinsurance | $326 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Mia would pay is** | **$756** |

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