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 www.dol.gov/agencies/ebsa or call 1-800-811-6322 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$ 0**	See the Common Medical Events chart below starting on page 2 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 **cost-sharing**. See the Common Medical Events chart starting on page 2 for a list of the specific services this plan covers without **cost-sharing**.
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 **out-of-pocket limit** 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 do not 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 a **referral**.

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	**Preventive care:** Adult* **Preventive care:** Children under 19 years of age – immunizations no charge. **Immunizations:** Limited to the CDC recommended guidelines for adults 19 and older for no charge.*	**Preventive care:** Adult-not covered. **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, approved alternative clinic, or in-network provider*. **Mammogram**: For women no charge for one baseline mammogram age 35-39, and one annual mammogram age 40 and over.* **GYN**: No charge for one annual exam and related tests. * **Colonoscopy**: One routine colonoscopy once every 5 years age 45 or over. * **Colorectal cancer screening test:** One screening once every 5 yrs age 45 or over for asymptomatic patients.* **Annual Flu Shot:** no charge for one annual influenza vaccine.* Adult immunizations covered in network only. You may have to pay for services that are not 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)	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.[insert].com	Generic drugs	20% **coinsurance**	20% **coinsurance**	Plan pays 100% 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	10% **coinsurance**	30% **coinsurance**	
	Inpatient services	10% **coinsurance**	40% **coinsurance**	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. The 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**	
	Habilitation services	$20 per visit **copay**, plus 20% **coinsurance**	40% **coinsurance**	
	Skilled nursing care	$20 per visit **co-pay**, plus 20% **coinsurance**	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 services covered. 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
- Long term care
- Private-duty nursing (except in connection with hospice care, home health care of step-down units)
- Weight loss programs

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 employeesonly)*
- 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 1-877-696-6775 or www.hhs.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 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 [1-800-811-6322.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-800-811-6322.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [1-800-811-6322.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-800-811-6322.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ The **plan's** overall **deductible**	$0	■ The **plan's** overall **deductible**	$0	■ The **plan's** overall **deductible**	$0
■ **Specialist** copayment	$20	■ **Specialist** copayment	$20	■ **Specialist** copayment	$20
■ Hospital (facility) coinsurance	10%	■ Hospital (facility) coinsurance	10%	■ Hospital (facility) coinsurance	10%
■ Other coinsurance	20%	■ Other coinsurance	20%	■ Other coinsurance	20%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Special office visits *(prenatal care)*		Primary care physician office visits *(including disease education)*		Emergency room care *(including medical supplies)*	
Childbirth/Delivery Professional Services		Diagnostic tests *(blood work)*		Diagnostic test *(x-ray)*	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment *(crutches)*	
Diagnostic tests *(ultrasounds and bloodwork)*		Durable medical equipment *(glucose meter)*		Rehabilitation services *(physical therapy)*	
Specialist visit *(anesthesia)*					
Total Example Cost	**$7,540**	**Total Example Cost**	**$5,400**	**Total Example Cost**	**$1,450**
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$0	Copayments	$20	Copayments	$180
Coinsurance	$1,140	Coinsurance	$996	Coinsurance	$254
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$0	Limits or exclusions	$300	Limits or exclusions	$0
The total Peg would pay is	**$1,140**	**Total Joe would pay is**	**$1,316**	**Total Mia would pay is**	**$434**

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

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