

## Sabin Metal Corporation: EPO Plan B

Coverage for: Individual, Family | Plan Type: EPO



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, see [www.ibatpa.com](http://www.ibatpa.com). 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-755-4414 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>In-Network:</b> \$750 individual / \$1,500 family  <b>Out-of-Network:</b> Not covered	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount 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 <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> (Embedded).
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive care, primary care services, emergency room, urgent care, and home health care are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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?	Yes. Prescription Drugs \$100 per individual	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In-Network:</b> \$6,500 individual / \$13,000 family  <b>Out-of-Network:</b> Not covered	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met (Embedded). Cost-share for Prescription drugs are included in the medical <a href="#">out-of-pocket limit</a> .
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-888-755-4414 for a list of participating providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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</a> office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	<a href="#">Specialist</a> visit	\$50 copay/visit	Not covered	
	<a href="#">Preventive care/screening</a> /immunization	No charge	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Labs/Blood work: No charge Xray: \$80 copay/visit	Not covered	Diagnostic services performed during an office visit will be covered at 100% and only the office visit copay will apply.
	Imaging (CT/PET scans, MRIs)	Deductible then \$150 copay/visit	Not covered	Pre-certification is required.
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.CarelonRX.com">www.CarelonRX.com</a>	Generic drugs (Tier 1)	Retail: \$5 copay/prescription Mail Order: \$7.50 copay/prescription	Not covered	For a \$0 copay – Contact CanaRx at 1-866-893-(MEDS) 6337
	Preferred brand drugs (Tier 2)	Retail: Deductible then \$45 copay/prescription Mail Order: Deductible then \$67.50 copay/prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: Deductible then \$90 copay/prescription Mail Order: Deductible then \$135 copay/prescription	Not covered	
	<a href="#">Specialty drugs</a>	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Center: Deductible then \$150 copay/visit Outpatient Hospital: Deductible then \$250 copay/visit	Not covered	Pre-certification is required.
	Physician/surgeon fees	Deductible then covered 100%	Not covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$300 copay/visit		If admitted the ER copay will be waived.
	<a href="#">Emergency medical transportation</a>	Deductible then covered 100%		
	<a href="#">Urgent care</a>	\$75 copay/visit		Copay will apply to facility only.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then \$250 copay/day	Not covered	Pre-certification is required. \$2,500 copay max per confinement.
	Physician/surgeon fee	Deductible then covered 100%	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 copay/visit	Not covered	Benefit includes Office treatment, Intensive Outpatient Therapy, and Partial Hospitalization.
	Inpatient services	Facility: Deductible then \$250 copay/day Professional: Deductible then covered 100%	Not covered	Pre-certification is required. Residential Treatment Centers are not covered. \$2,500 copay max per confinement.
If you are pregnant	Office visits	No charge	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of service, a <a href="#">copayment</a> may apply.
	Childbirth/delivery professional services	Deductible then covered 100%	Not covered	
	Childbirth/delivery facility services	\$250 copay/day	Not covered	Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a claim denial. \$2,500 copay max per confinement.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$50 copay/visit	Not covered	Pre-certification is required. Limited to 30 visits per year.
	<a href="#">Rehabilitation services</a>	\$50 copay/visit	Not covered	Limited to 30 visits per therapy per year for Physical, Occupational, and Speech therapy.
	<a href="#">Habilitation services</a>	\$50 copay/visit	Not covered	Limited to 30 visits per therapy per year for Physical, Occupational, and Speech therapy.
	<a href="#">Skilled nursing care</a>	Deductible then \$250 copay/day	Not covered	Pre-certification is required. Limited to 200 days per year. \$2,500 copay max per confinement.
	<a href="#">Durable medical equipment</a>	Deductible then 10% coinsurance	Not covered	Pre-certification is required.
	<a href="#">Hospice services</a>	Deductible then \$250 copay/day	Not covered	Pre-certification is required for inpatient and home hospice. Limited to 200 days per lifetime. \$2,500 copay max per confinement.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$30 copay/visit	Not covered	1 exam per year up to age 19 for glasses/contacts exam. If billed under ACA guidelines during a well visit with pediatrician there is no charge.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge	Not covered	

#### 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](#).)

<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty Nursing</li> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>
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##### Other Covered Services (This isn't a complete list. Check your policy or [plan](#) document for other covered services and your costs for these services.)

<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture (limited to 35 visits per year)</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic Care (limited to 30 visits per year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids (limited to \$1,500 per ear every 3 years)</li> </ul>
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**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 the plan at 1-888-755-4414. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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](#).

*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)		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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> [ <a href="#">copayment</a> ]	\$50	■ <a href="#">Specialist</a> [ <a href="#">copayment</a> ]	\$50	■ <a href="#">Specialist</a> [ <a href="#">copayment</a> ]	\$50
■ Hospital (facility) [ <a href="#">copayment</a> ]	\$250	■ Hospital (facility) [ <a href="#">copayment</a> ]	\$250	■ Hospital (facility) [ <a href="#">copayment</a> ]	\$250
■ Other [ <a href="#">coinsurance</a> ]	0%	■ Other [ <a href="#">coinsurance</a> ]	0%	■ Other [ <a href="#">coinsurance</a> ]	10%
This EXAMPLE event includes services like: <a href="#">Primary care physician</a> office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> ) <a href="#">Specialist</a> visit ( <i>anesthesia</i> )		This EXAMPLE event includes services like: <a href="#">Primary care physician</a> office visits ( <i>including disease education</i> ) <a href="#">Diagnostic tests</a> ( <i>blood work</i> ) <a href="#">Prescription drugs</a> <a href="#">Durable medical equipment</a> ( <i>glucose meter</i> )		This EXAMPLE event includes services like: <a href="#">Emergency room care</a> ( <i>including medical supplies</i> ) <a href="#">Diagnostic test</a> ( <i>x-ray</i> ) <a href="#">Durable medical equipment</a> ( <i>crutches</i> ) <a href="#">Rehabilitation services</a> ( <i>physical therapy</i> )	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
<a href="#">Deductibles</a>	\$750	<a href="#">Deductibles</a>	\$750	<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$500	<a href="#">Copayments</a>	\$360	<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$0	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$1,250	The total Joe would pay is	\$1,110	The total Mia would pay is	\$1,550