Sabin Metal Corporation: HSA Plan C

Coverage for: Individual, Family | **Plan Type:** HSA 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. 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 or call 1-888-755-4414 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network:** **$2,700** individual **$4,050** employee + child/children **$5,400** employee + spouse **$5,400** family **Out-of-Network:** Not covered	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. (Non-Embedded).
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription Drugs **$100 per individual**	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for services.
What is the out-of-pocket limit for this plan?	**In-Network:** **$6,000** individual **$9,000** employee + child/children **$12,000** employee + spouse **$12,000** family **Out-of-Network:** Not covered	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on the plan, the overall family out-of-pocket limit must be met before the plan begins to pay. (Non-Embedded). Cost-share for Prescription drugs are included in the medical out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not 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. See **www.anthem.com** or call **1-888-755-4414** for a list of participating 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). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	Deductible then covered 100%	Not covered	
	Specialist visit	Deductible then covered 100%	Not covered	
	Preventive care/screening/immunization	No charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Not covered	Pre-certification is required.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.CarelonRX.com**	Generic drugs (Tier 1)	Retail: $5 copay/prescription Mail Order: $5 copay/prescription	Not covered	Deductible is waived for generic drugs. Covers up to 30-day supply. Two copays will apply for 30-60 day supply. Three copays apply for 61-100 day supply. For no coinsurance after deductible – Contact CanaRx at 1-866-893-(MEDS) 6337
	Preferred brand drugs (Tier 2)	Retail: Deductible then 20% coinsurance/prescription Mail Order: Deductible then 20% coinsurance/prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail:	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)	
		Deductible then 50% coinsurance/prescription Mail Order: Deductible then 50% coinsurance/prescription		
	Specialty drugs	Generic/Preferred: Deductible then 20% coinsurance/prescription Non-Preferred: Deductible then 50% coinsurance/prescription	Not covered	Specialty drugs are subject to a dispensing limit of 30-day supply. Must be received from the preferred specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Not covered	Pre-certification is required.
	Physician/surgeon fees	Deductible then 20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	Deductible then 20% coinsurance		
	Emergency medical transportation	Deductible then 20% coinsurance		
	Urgent care	Deductible then 20% coinsurance		
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Not covered	Pre-certification is required.
	Physician/surgeon fee	Deductible then 20% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible then 20% coinsurance	Not covered	Benefit includes Office treatment, Intensive Outpatient Therapy, and Partial Hospitalization.
	Inpatient services	Deductible then 20% coinsurance	Not covered	Pre-certification is required. Residential Treatment Centers are not covered.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Depending on the type of service, a deductible and coinsurance may apply (non-routine office visits).
	Childbirth/delivery professional services	Deductible then 20% coinsurance	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)	
	Childbirth/delivery facility services	Deductible then 20% coinsurance	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.
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Not covered	Pre-certification is required. Limited to 30 visits per year.
	Rehabilitation services	Deductible then 20% coinsurance	Not covered	Limited to 30 visits per therapy per year for Physical, Occupational, and Speech therapy.
	Habilitation services	Deductible then 20% coinsurance	Not covered	Limited to 30 visits per therapy per year for Physical, Occupational, and Speech therapy.
	Skilled nursing care	Deductible then 20% coinsurance	Not covered	Pre-certification is required. Limited to 200 days per year.
	Durable medical equipment	Deductible then 20% coinsurance	Not covered	Pre-certification is required.
	Hospice services	Deductible then 20% coinsurance	Not covered	Pre-certification is required for inpatient and home hospice. Limited to 200 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Deductible then 20% coinsurance	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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Abortion
- Acupuncture (limited to 35 visits per year)
- Bariatric surgery
- Hearing Aids (limited to $1,500 per ear every 3 years)

	• Chiropractic Care (limited to 30 visits per year)	

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. 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 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.

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)	
The plan's overall deductible	$2,700
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%
This EXAMPLE event includes services like:	
Primary care physician 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	$2,700
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,700**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	$2,700
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,700
Copayments	$60
Coinsurance	$568
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,328**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	$2,700
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,720**

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