



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 including your plan's Summary plan description, visit www.sheetmetalsam.org or call the Administrative Office at **1-800-947-4338**. 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/ebsa/healthreform or call the Administrative Office at 1-800-947-4338 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p><u>Network Providers</u> per calendar year: \$300/individual; \$900/family. <u>Out-of-Network Providers</u> per calendar year: \$600/individual; \$1,800/family.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
Are there services covered before you meet your deductible?	<p>Yes. <u>Preventive care</u> performed by <u>network providers</u>, treatment received within 72 hours of an accidental injury, outpatient <u>prescription drugs</u>, dental <u>plan</u> (if elected), and vision <u>plan</u> (if elected) are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
Are there other deductibles for specific services?	<p>No. There are no other specific <u>deductibles</u>.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
What is the out-of-pocket limit for this plan?	<p>Medical <u>Plan Network Provider</u>: \$3,900/individual; \$7,800/family per calendar year. <u>Out-of-Network Provider</u>: No <u>out-of-pocket limit</u>. Outpatient <u>prescription drugs</u> per calendar year: \$2,500/individual; \$5,000/family.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
What is not included in the out-of-pocket limit?	<p>For the Medical <u>Plan</u>: <u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>preauthorization</u>, dental & vision <u>plan</u> expenses, outpatient retail/mail order drug expenses (which have a separate <u>out-of-pocket limit</u>), and out-of-<u>network cost sharing</u> except an ER visit in case of an emergency. The outpatient <u>prescription drug out-of-pocket limit</u> does not include <u>premiums</u>, <u>balance-billing</u> charges, medical <u>plan</u>, dental <u>plan</u>, or vision <u>plan</u> expenses, or drugs/health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. For medical see www.anthem.com or call 1-800-888-8288 for a list of <u>Network Providers</u> . For substance abuse related providers call "Beat It" at 1-800-828-3939.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral to see a specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> of certain services such as sleep therapy, surgery, pain management, vision therapy and hormone therapy is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850.
	<u>Specialist</u> visit	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> .	<u>Plan</u> covers required <u>preventive services</u> and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ . Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	Physician/ <u>provider's</u> professional fees may be billed separately.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	Physician/ <u>provider's</u> professional fees may be billed separately.
If you need drugs to treat your illness or condition	Generic drugs	Retail Pharmacy for 30-day supply: \$10 <u>copayment</u> per prescription; Mail Order for 90-day supply: \$15 <u>copayment</u> per prescription. No charge for FDA-approved generic contraceptives.	Not covered.	<ul style="list-style-type: none"> <u>Deductible</u> does not apply. Certain preferred brand insulins are subject to a maximum <u>copayment</u> of \$25 per prescription for a 30-day supply.

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)	
More information about prescription drug coverage is available at www.express-scripts.com or call 1-800-349-3780.	Preferred brand drugs	Retail Pharmacy for 30-day supply: \$30 <u>copayment</u> per prescription; Mail Order for 90-day supply: \$45 <u>copayment</u> per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.		<ul style="list-style-type: none"> Some prescription drugs are subject to <u>preauthorization</u> (to avoid non-payment), quantity limits or step therapy requirements. If the cost of the drug is less than the <u>copayment</u>, you pay just the drug cost. Certain over-the-counter (OTC) and <u>prescription drugs</u> are payable at no charge with a prescription.
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: \$45 <u>copayment</u> per prescription; Mail Order for 90-day supply: \$68 <u>copayment</u> per prescription.		
	<u>Specialty drugs</u>	\$10 <u>copayment</u> per prescription for up to a 30-day supply.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization</u> of surgery is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850.
	Physician/surgeon fees	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u> plus a \$75 <u>copayment</u> /visit.	30% <u>coinsurance</u> plus a \$75 <u>copayment</u> /visit.	Physician/ <u>provider</u> 's professional fees may be billed separately. <u>Copayment</u> waived if hospitalized.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u> .	30% <u>coinsurance</u> .	None.
	<u>Urgent care</u>	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	Physician/ <u>provider</u> 's professional fees may be billed separately.

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 have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<p><u>Preauthorization</u> of transplant services is required to avoid non-payment of services. <u>Preauthorization</u> of a hospital admission and surgery is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850. Private room payable only if <u>medically necessary</u>.</p>
	Physician/surgeon fees	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: 30% <u>coinsurance</u> . Other outpatient services: 30% <u>coinsurance</u> .	Office visits: 50% <u>coinsurance</u> . Other outpatient services: 50% <u>coinsurance</u> .	None.
	Inpatient services	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<p><u>Preauthorization</u> of a mental health related hospital admission is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850.</p> <p><u>Preauthorization</u> of a substance abuse related admission is encouraged by calling "Beat It" at 1-800-828-3939.</p>
If you are pregnant	Office visits	30% <u>coinsurance</u> ; no charge and <u>deductible</u> does not apply for ACA-required <u>preventive services</u> .	50% <u>coinsurance</u> ; <u>preventive services</u> subject to <u>out-of-network deductible</u> .	<ul style="list-style-type: none"> • <u>Cost sharing</u> does not apply for <u>network preventive services</u>. • Depending on the type of services, <u>coinsurance</u> may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). • Prenatal care (other than office visits and ACA-required <u>preventive screenings</u>) is not covered for dependent children.
	Childbirth delivery professional services	For employee and spouse only: 30% <u>coinsurance</u> .	For employee and spouse only: 50% <u>coinsurance</u> .	<ul style="list-style-type: none"> • You must pay 100%, even <u>in-network</u>, for ultrasounds and delivery expenses for a dependent child. • <u>Preauthorization</u> is encouraged only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section. • Includes Birthing Centers and Certified Nurse-Midwife
	Childbirth delivery facility services	For employee and spouse only: 30% <u>coinsurance</u> .	For employee and spouse only: 50% <u>coinsurance</u> .	

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	<u>Home health care</u>	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization of home health care</u> and home infusion therapy is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850.
	<u>Rehabilitation services</u>	Outpatient visits: 30% <u>coinsurance</u> . Inpatient Rehab. Admission: 30% <u>coinsurance</u> .	Outpatient visits: 50% <u>coinsurance</u> . Inpatient Rehab. Admission: 50% <u>coinsurance</u> .	<ul style="list-style-type: none"> • Outpatient physical therapy maximum (including cardiac rehabilitation) benefit is 32 visits per calendar year. • <u>Preauthorization of physical and speech therapy</u> is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850. • Maximum inpatient rehabilitation admission 60 days per calendar year. Admission must begin within 14 days following a period of 3 days in an acute hospital for the same condition.
	<u>Habilitation services</u>	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization of physical and speech therapy</u> is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	Maximum 60 days per calendar year. Admission must begin within 14 days following a period of 3 days in an acute hospital for the same condition.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u> .	50% <u>coinsurance</u> .	<u>Preauthorization of durable medical equipment</u> is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850. No charge from <u>network providers</u> for breastfeeding pump and supplies needed to operate pump.
	<u>Hospice services</u>	30% <u>coinsurance</u> .	30% <u>coinsurance</u> .	Covered if terminally ill (as defined in the Glossary).

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 your child needs dental or eye care	Children's eye exam	\$15 <u>copayment</u> /visit. Medical <u>plan deductible</u> does not apply.	You pay 100%. <u>Plan</u> reimburses up to \$45 per exam (minus the \$15 <u>copayment</u> for the exam). You pay any amount over \$45 for exam. Medical <u>plan deductible</u> does not apply.	<ul style="list-style-type: none"> When elected, Vision coverage is provided through the Anthem Blue View Vision <u>plan</u>. One eye exam per 12 consecutive months. One frame per 24 consecutive months. One pair of lenses per 12 months. Your <u>cost sharing</u> for vision services does not count toward the medical <u>plan's out-of-pocket limit</u>.
	Children's glasses	No charge up to \$120 per eyeglass frame and lenses. You pay any amount over \$120 and get a 20% discount off any remaining balance. Medical <u>plan deductible</u> does not apply.	You pay 100%. <u>Plan</u> reimburses up to \$47/frame and up to \$45/single lens. You pay any amount over \$47/frame and \$45/single lens. Medical <u>plan deductible</u> does not apply.	
	Children's dental check-up	Your cost depends on the separate dental <u>plan</u> you are eligible for (if elected). Medical <u>plan deductible</u> does not apply.	Your cost depends on the separate dental <u>plan</u> you are eligible for (if elected). Medical <u>plan deductible</u> does not apply.	

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.)

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| <ul style="list-style-type: none"> Cosmetic surgery Hearing aids | <ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing | <ul style="list-style-type: none"> Routine foot care Weight loss programs, except as required by health reform law. |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> Acupuncture (up to 20 visits per calendar year) Bariatric Surgery | <ul style="list-style-type: none"> Chiropractic care (up to 20 visits per calendar year). Dental care (Adult) (if elected, benefits will be available through separate dental <u>plan</u>) | <ul style="list-style-type: none"> Infertility treatment (services for diagnosis only are covered) Routine eye care (Adult) (if elected, benefits will be available through separate vision <u>plan</u>) |
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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 the 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: Administrative Office at 1-800-947-4338, or the Department of Labor's 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. Contact the Help Center of the California Department of Managed Health Care at (888) 466-2219. This website lists states with a Consumer Assistance Program: <https://www.cms.gov/ccio/resources/consumer-assistance-grants/>.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-947-4338.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-947-4338.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-947-4338.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-947-4338.

————— *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 <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> <u>coinsurance</u>	30%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	30%
■ <u>Other</u> <u>coinsurance</u>	30%

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	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$3,250
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Peg would pay is	\$3,580

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> <u>coinsurance</u>	30%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	30%
■ <u>Other</u> <u>coinsurance</u>	30%

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
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$730
<u>Coinsurance</u>	\$210
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,240

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> <u>coinsurance</u>	30%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	30%
■ <u>Other</u> (ER <u>copayment</u>)	\$75

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
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$730
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,110

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