Sheet Metal Workers' Health Plan
of Southern California, Arizona & Nevada

January 2027

Summary Comparison

Of

Medical Plan Options

Plan A

Includes HMO Plan Options Available in

Nevada

To ensure the best coverage is available for you and your eligible dependents, please review this comparison very carefully. **Once you have elected a medical plan, you may change your election only during the next Annual Open Enrollment.** Exceptions are made only if you move outside of your selected plan's service area, so please ***choose carefully***.

All completed enrollment forms received by the 15th of the month are processed for an effective date of the 1st day of following month.

Aviso a los participantes que hablan español: Si tiene alguna pregunta por favor no dude en comunicarse con la Oficina Administrativa al 800-947-4338, donde habrá varios representantes bilingües que con gusto le ayudarán.

Important: This **is <u>not</u> a contract. This is a *summary* of the medical plan options available to you. The group agreements and Plan documents must be consulted to determine the exact terms and conditions of coverage. All benefits are subject to change.**

The Fee**-for-Service Plan** - is a comprehensive major medical plan which offers you the flexibility of "choice". Under this Plan, you may use any doctor or go to any facility you choose, within the United States. If you utilize a provider participating in the Plan's PPO network, however, your out-of-pocket expenses are greatly reduced. **To avoid additional unexpected out-of-pocket expenses, pre-authorization is highly recommended prior to receiving certain services, as indicated by an asterisk (*). For pre-authorization, please call Anthem Blue Cross at 800-832-7850.**

The **HMO and EPO Plans** (*Health Maintenance Organization / Exclusive Provider Organization)* - provide quality care under a **managed care** environment, within a **defined service area.** When you enroll in an HMO or EPO plan, you <u>must</u> use their medical providers and hospitals for all of your medical care, including prescription drugs. **No benefits are provided if you, or *your eligible dependents*, use non-contracted providers**, except for certain medical emergencies. There are no claim forms to fill out, and the Fund pays the HMO/EPO directly for your health care needs. Most routine health care services are provided to you for specified co-payment amounts at the time of service, but deductibles and co-insurances apply to others.

Each HMO/EPO has a limited service **area**, which is defined in each enrollment packet. To enroll in an HMO or EPO, you must reside in and have all medical services performed within their defined service area. **<u>If you enroll in an HMO or EPO and have an eligible dependent(s) residing in a separate household which is *outside* of your selected Plan's service area *(i.e. college students, adult children, or children residing with ex-spouses)*, there may be no benefits available for that dependent</u>**. In addition, if you travel out of town to work, or plan to do so, **you may have <u>no</u> benefits available** while you are outside of your selected plan's service area.

Active Plan A – Nevada 2027	**Fee-for-Service (Anthem Blue Cross)** ***Self-funded Plan***		**United Healthcare** ***Choice EPO Plan***	**Health Plan of Nevada** ***Solutions Value HMO***	**Kaiser Permanente Nevada (Formerly Hometown Health)** ***HMO Plan***
Plan Feature	**All benefits are payable based on the allowable charges, as defined in the Summary Plan Description.** **Pre-authorization is recommended for all benefits indicated with an asterisk (*).**				Available in **Northern Nevada** <u>only</u>
	PPO Provider	**Non-PPO Provider**			
Annual Deductible	$300 per person; maximum of 3 deductibles per family **Deductible applies to most services**	$600 per person; maximum of 3 deductibles per family **Deductible applies to most services**	$500 per person; $1,000 per family maximum **Deductible applies unless otherwise noted**	$500 per person; $1,000 per family maximum **Deductible applies unless otherwise noted**	$500 per person; $1,000 per family maximum **Deductible applies unless otherwise noted**
Annual Out-of-Pocket Limit	Plan pays 100% of allowable charges after you have incurred a total of $3,400 out-of-pocket per year *($6,800 for a family)*	None Benefits do not increase from 50%	Plan pays 100% after eligible out-of-pocket costs reach $3,000 in a year *($6,000 for a family)*	Plan pays 100% after eligible out-of-pocket costs reach $2,000 in a year *($6,000 for a family)*	Plan pays 100% after eligible out-of-pocket costs reach $3,000 in a year *($6,000 per family)*
In Patient Hospital	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Out Patient Hospital	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	You pay $350 per procedure after deductible	You pay $200 per procedure after deductible
Extended Care Facility *(Skilled Nursing)*	Plan pays 75% of allowable charges after deductible; 60 days maximum per calendar year	Plan pays 50% of allowable charges; 60 days maximum per calendar year	Plan pays 80% after deductible; 100 days maximum per calendar year	You pay $300 per admission after deductible, waived if admitted from an acute care facility; 100 days maximum per calendar year	Plan pays 80% after deductible; 100 days maximum per calendar year
Office Visits			***Not Subject to Deductible***	***Not Subject to Deductible***	***Not Subject to Deductible***
Primary Care Physician	Plan pays 75% after deductible	Plan pays 50% of allowable charges	You pay $30 per visit	You pay $25 per visit	You pay $30 per visit
Specialist	Plan pays 75% after deductible	Plan pays 50% of allowable charges	You pay $50 per visit	You pay $50 per visit	You pay $50 per visit
Preventative Care	***Not Subject to Deductible***		***Not Subject to Deductible***	***Not Subject to Deductible***	***Not Subject to Deductible***
Routine Exam- Adults	Plan pays 100% of allowable charges, including all tests	Plan pays 50% of allowable charges, including all tests	Plan pays 100%	Plan pays 100%	Plan pays 100%
Routine Exam-Children	Plan pays100% of allowable charges for at least 11 visits during1st 30 months of age, then 1 visit every year through age 18	Plan pays 50% of allowable charges for at least 11 visits during1st 30 months of age, then 1 visit every year through age 18	Plan pays 100%	Plan pays 100%	Plan pays 100%
Immunizations	Plan pays 100% of allowable charges	Plan pays 50% of allowable charges	Plan pays 100%	Plan pays 100%	Plan pays 100%
Diagnostic X-ray & Lab	Plan pays 75% after deductible	Plan pays 50% of allowable charges	Plan pays 100%; deductible does not apply	You pay $15 for lab work and $25 for x-rays; deductible does not apply	Plan pays 100% for lab work; you pay $50 for x-rays; deductible does not apply
CAT Scans & MRI's	Plan pays 75% after deductible	Plan pays 50% of allowable charges	You pay $100 per test after deductible	Plan pays 80% after deductible	You pay $100 per test: deductible does not apply
Durable Medical Equipment	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	Plan pays 100%; deductible does not apply	Plan pays 80% after deductible
Home Health Care	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible, up to 100 visits per calendar year	You pay $35 per visit; deductible does not apply; *prior authorization required*	You pay $50 per visit, up to 30 visits per calendar year, deductible does not apply
Chiropractic Care	Plan pays 100% after deductible, limit of 20 visits per year	Plan pays 75% of allowable charges after deductible, limit of 20 visits per year	You pay $50 per visit, up to 24 visits per calendar year; deductible does not apply	You pay $25 per visit, *referral required*, up to 20 visits per calendar year, deductible does not apply	You pay $50 per visit, up to 20 visits per calendar year/100 visits per lifetime; deductible does not apply

Physical Therapy	*Plan pays 75% after deductible; limit of 32 visits per year	*Plan pays 50% of allowable charges; limit of 32 visits per year	You pay $50 per visit, unlimited visits per calendar year; deductible does not apply	You pay $25 per visit; up to 60 days/visits per calendar year; deductible does not apply	You pay $30 per visit, up to 90 visits per calendar year for all 3 therapies; deductible does not apply
Speech Therapy	*Plan pays 75% of allowable charges after deductible	*Plan pays 50% of allowable charges	You pay $50 per visit, unlimited visits per calendar year; deductible does not apply	You pay $25 per visit, up to 60 days/visits per calendar year; deductible does not apply	You pay $30 per visit, up to 90 visits per calendar year for all 3 therapies; deductible does not apply
Maternity Care	Same as an illness except routine prenatal visits to a PPO provider paid at 100% with no deductible		Same as an illness except no co-pay for routine prenatal visits	Same as an illness except no co-pay for routine prenatal visits	Same as an illness except no co-pay for routine prenatal visits
Mental Health and Substance Abuse Care	**For substance abuse care, you may choose the Anthem Blue Cross PPO program, or the *Beat It!* Program**		**For substance abuse care, you may choose between coverage under the *Beat It!* Program or your HMO, or a combination of both**		
Inpatient	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Outpatient	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	You pay $20 per visit; deductible does not apply	You pay $25 per visit; deductible does not apply	You pay $30 per visit; deductible does not apply;
Prescription Drugs	**Must be obtained at an *ExpressScripts* Network pharmacy**		***Must be obtained at a participating HMO pharmacy***		
	Not Subject to Deductible		***Not Subject to Deductible***	***Not Subject to Deductible***	***Not Subject to Deductible***
Annual Out-of-Pocket Limit	Plan pays 100% after Rx co-pays reach $3,200 per year *($6,400 for a family)*		Included in Medical Out-of-Pocket Limit	Included in Medical Out-of-Pocket Limit	Included in Medical Out-of-Pocket Limit
Short Term *(outpatient)*	You pay $10 per generic, $30 per brand name, and $45 per non-preferred prescription, up to a 30-day supply		You pay $20 per formulary generic, $40 per formulary brand, and $60 per non-formulary prescription, up to a 30-day supply	You pay $20 per Tier I, $40 per Tier II, and $70 per Tier III prescription, up to a 30-day supply	You pay $20 per formulary generic, $40 per formulary brand, and $60 per non-formulary prescription, up to a 30-day supply
Maintenance (*30-day supply or more through the Mail Order)*	***ExpressScripts* Mail Order Pharmacy** - You pay $15 per generic, $45 per brand name and $68 per non-preferred prescription, up to a 90-day supply		**Mail Order -** You pay $50 per formulary generic, $100 per formulary brand, and $150 per non-formulary prescription, up to a 90-day supply	**Mail Order -** You pay $50 per Tier I, $100 per Tier II, and $175 per Tier III prescription, up to a 90-day supply	**Mail Order -** You pay $40 per formulary generic, $80 per formulary brand, and $120 per non-formulary prescription, up to a 90-day supply
Hearing Aids	Plan pays 100% up to $2,000 per device; one device for each ear every 3 years; deductible does not apply		Plan pays 80% after deductible; maximum benefit of $2,500 every 3 years	Plan pays 100%; limited to a single purchase of a type of hearing aid, including repairs & replacement once every 3 years; deductible does not apply	**Not Covered**
Emergency Room Care	You pay a $75 co-pay per Emergency Room visit, plus the balance due after the remaining expenses have been processed according to the regular Plan benefits, subject to the calendar year deductible and co-insurance percentages. The $75 co-pay is waived if admitted to the hospital. Benefits will be paid only if the condition fits the Plan's definition of emergency – refer to your Summary Plan Description booklet for details		You pay $250 per visit after deductible	You pay $250 per visit, plus 20% of EME, ($250 co-pay waived if admitted); deductible does not apply	You pay $250 per visit; deductible does not apply

THIS IS ONLY A SUMMARY: The above Plan benefits show only a partial summary of benefits. Please refer to the applicable Evidence of Coverage (EOC) booklet or Summary Plan Description booklet for prior-authorization requirements and specific restrictions, exclusions, and limitations.

Regardless of which medical plan you select, **your Dental, Vision, Death Benefits, and Accidental Death & Dismemberment Benefits** will continue to be provided by the Trust Fund**.**

Questions?

For ***Specific Benefits*** available, please call the appropriate Member Service numbers indicated below:

Anthem Blue Cross	800-888-8288
Health Plan of Nevada HMO Plan	800-777-1840
Kaiser Permanente Nevada HMO Plan (Formerly Hometown Health)	775-982-5000
United Healthcare Choice EPO Plan	800-377-5154

For information on specific benefits under the **Fee-for-Service/PPO Plan**, you may contact the **Health Department** of the Administrative Office, at **800-947-4338, option 1**.

For information on your ***Eligibility*** or ***Hour Bank*** status, or if you are not sure which plan you are currently enrolled on, please contact the **Health Department** of the Administrative Office, at **800-947-4338, option 3.**

Moving?

Please contact the Eligibility Department at the Administrative Office *immediately* if you change your mailing address! If you are enrolled in an HMO, ***a change of residence could result in a lapse of coverage!***

Please review and retain this Summary for future use. It contains the most current information on the plans available, as well as the current benefits effective January 1, 2027. All benefits are subject to change.



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of Southern California, Arizona & Nevada

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