1/1/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?	Network Providers per calendar year: $300/individual; $900/family. Out-of-Network Providers per calendar year: $600/individual; $1,800/family.	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care performed by network providers, hearing aids, treatment received within 72 hours of an accidental injury, outpatient prescription drugs, dental plan (if elected), and vision plan (if elected) are 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?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical Plan Network Provider: $3,400/individual; $6,800/family per calendar year. Out-of-Network Provider: No out-of-pocket limit. Outpatient prescription drugs per calendar year: $3,200/individual; $6,400/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	For the Medical Plan: Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization, dental & vision plan expenses, outpatient retail/mail order drug expenses (which have a separate out-of-pocket limit), and out-of-network cost sharing except an ER visit in case of an emergency. The outpatient prescription drug out-of-pocket limit does not include premiums, balance-billing charges, medical plan, dental plan, or vision plan expenses, or drugs/health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. For medical providers, see www.anthem.com or call 1-800-888-8288 for a list of Network Providers. For substance abuse related providers call "Beat It" at 1-800-828-3939.	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.

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	25% coinsurance.	50% coinsurance.	Preauthorization 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.
	Specialist visit	25% coinsurance.	50% coinsurance.	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance.	Plan covers required preventive services and supplies described at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive care. 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)	25% coinsurance.	50% coinsurance.	Physician/provider's professional fees may be billed separately.
	Imaging (CT/PET scans, MRIs)	25% coinsurance.	50% coinsurance.	Physician/provider's 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 copayment per prescription; Mail Order for 90-day supply: $15 copayment per prescription. No charge for FDA-approved generic contraceptives.	Not covered.	• Deductible does not apply. • Certain preferred brand insulins are subject to a maximum copayment 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 copayment per prescription; Mail Order for 90-day supply: $45 copayment per prescription. No charge for FDA-approved brand name contraceptives if a generic is medically inappropriate.		• Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • If the cost of the drug is less than the copayment, you pay just the drug cost. • Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription.
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: $45 copayment per prescription; Mail Order for 90-day supply: $68 copayment per prescription.		
	Specialty drugs	$10 copayment per prescription for up to a 30-day supply.	Not covered.	Deductible does not apply. Specialty drugs require preauthorization (to avoid non-payment) by calling Accredo at 1-800-803-2523.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance.	50% coinsurance.	Preauthorization 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	25% coinsurance.	50% coinsurance.	
If you need immediate medical attention	Emergency room care	25% coinsurance plus a $75 copayment/visit.	25% coinsurance plus a $75 copayment/visit.	Physician/provider's professional fees may be billed separately. Copayment waived if hospitalized.
	Emergency medical transportation	25% coinsurance.	25% coinsurance.	None.
	Urgent care	25% coinsurance.	50% coinsurance.	Physician/provider's professional fees may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance.	50% coinsurance.	Preauthorization of transplant services is required to avoid non-payment of services. Preauthorization 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 medically necessary.
	Physician/ surgeon fees	25% coinsurance.	50% coinsurance.	
If you need mental health, behavioral	Outpatient services	Office visits: 25% coinsurance. Other outpatient services: 25% coinsurance.	Office visits: 50% coinsurance. Other outpatient services: 50% coinsurance.	None.

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)	
health, or substance abuse services	Inpatient services	25% coinsurance.	50% coinsurance.	Preauthorization 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. Preauthorization of a substance abuse related admission is encouraged by calling "Beat It" at 1-800-828-3939.
If you are pregnant	Office visits	25% coinsurance; no charge and deductible does not apply for ACA-required preventive services.	50% coinsurance; preventive services subject to out-of-network deductible.	• Cost sharing does not apply for network preventive services. • Depending on the type of services, coinsurance 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 preventive screenings) is not covered for dependent children.
	Childbirth delivery professional services	For employee and spouse only: 25% coinsurance.	For employee and spouse only: 50% coinsurance.	• You must pay 100%, even in-network, for ultrasounds and delivery expenses for a dependent child. • Preauthorization 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: 25% coinsurance.	For employee and spouse only: 50% coinsurance.	

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	25% coinsurance.	50% coinsurance.	Preauthorization of home health care and home infusion therapy is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850.
	Rehabilitation services	Outpatient visits: 25% coinsurance. Inpatient Rehab. Admission: 25% coinsurance.	Outpatient visits: 50% coinsurance. Inpatient Rehab. Admission: 50% coinsurance.	• Outpatient physical therapy maximum (including cardiac rehabilitation) benefit is 32 visits per calendar year. • Preauthorization of physical and speech therapy 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.
	Habilitation services	25% coinsurance.	50% coinsurance.	Preauthorization of physical and speech therapy is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850.
	Skilled nursing care	25% coinsurance.	50% coinsurance.	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.
	Durable medical equipment	25% coinsurance.	50% coinsurance.	Preauthorization of durable medical equipment is encouraged by calling Anthem in California at 1-800-274-7767 or in Nevada call 1-800-832-7850. No charge from network providers for breastfeeding pump and supplies needed to operate pump.
	Hospice services	25% coinsurance.	25% coinsurance.	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 copayment/visit. Medical plan deductible does not apply.	You pay 100%. Plan reimburses up to $45 per exam (minus the $15 copayment for the exam). You pay any amount over $45 for exam. Medical plan deductible does not apply.	• When elected, Vision coverage is provided through the Anthem Blue View Vision plan. • One eye exam per 12 consecutive months. • One frame per 24 consecutive months. • One pair of lenses per 12 months. • Your cost sharing for vision services does not count toward the medical plan's out-of-pocket limit.
	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 plan deductible does not apply.	You pay 100%. Plan reimburses up to $47/frame and up to $45/single lens. You pay any amount over $47/frame and $45/single lens. Medical plan deductible does not apply.	
	Children's dental check-up	Your cost depends on the separate dental plan you are eligible for (if elected). Medical plan deductible does not apply.	Your cost depends on the separate dental plan you are eligible for (if elected). Medical plan deductible does not apply.	• When elected, dental coverage is available under a separate dental plan through the Delta Dental DMO (called DeltaCare USA) or Delta Dental PPO. • Your cost sharing for dental services does not count toward the medical plan's out-of-pocket limit.

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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs, except as required by health reform law.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (up to 20 visits per calendar year)
- Bariatric Surgery
- Chiropractic care (up to 20 visits per calendar year).
- Dental care (Adult and Child) (If elected, benefits will be available through separate dental plan)
- Hearing aids (payable at 100% up to $2,000/ear once each 3 years)
- Infertility treatment (only services for diagnosis are covered)
- Routine eye care (Adult) (if elected, benefits will be available through separate vision plan)

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/cciio/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, kwiijigo 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 plan's overall deductible	$300
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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**

In this example, Peg would pay:

Cost sharing	
Deductibles	$300
Copayments	$10
Coinsurance	$2,710
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,040**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$300
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$300
Copayments	$730
Coinsurance	$210
What isn't covered	
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 plan's overall deductible	$300
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other (ER copayment)	$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**

In this example, Mia would pay:

Cost sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$610
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$990**

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