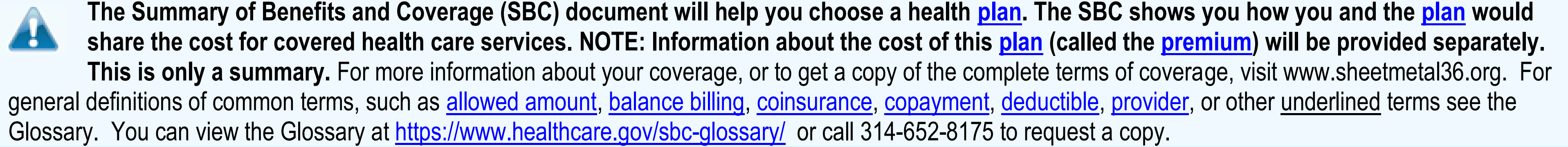
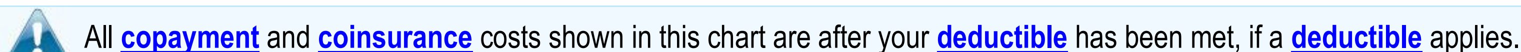


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.sheetmetal36.org. 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 https://www.healthcare.gov/sbc-glossary/ or call 314-652-8175 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Tier 1: $200** person/**$600** family **Tier 2: $500** person/**$1,500** family **Tier 3: $1,000** person/ **$3,000** 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 is covered before you meet your deductible. The deductible applies to all services, unless otherwise noted in the chart starting on page 2.	This plan covers some items and services before you meet the deductible amount but a copayment or coinsurance may apply. For example, this plan covers specific 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. Durable Medical Equipment is subject to a separate individual/family deductible of $200/$600 for Tier 1, $500/$1,500 for Tier 2 and $1,000/$3,000 for Tier 3.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Tier 1: $4,000** person/ **$8,000** family **Tier 2: $4,000** person/ **$8,000** family **Prescription: $2,850** person/**$5,700** family **In-Network Specialty Drugs: $500** person	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?	Vision and dental services, premiums, balance-billing charges, and services this plan doesn't 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.cmrnetwork.com or call 314-652-8175 for a list of network 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.	This plan will pay some or all of the costs to see a specialist for covered services and you can see the specialist without permission from this plan.


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	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network or Out of Area Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	$35 copayment/visit	50% coinsurance	———none———
	Specialist visit	$40 copayment/visit	$50 copayment/visit	50% coinsurance	———none———
	Preventive care/screening/immunization	No Charge	No Charge	Not Covered	———none———
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	20% coinsurance No deductible	30% coinsurance No deductible	50% coinsurance No deductible	———none———
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ldi.com.	Generic drugs	$15 copayment retail $37.50 copayment mail order No deductible		Not Covered	LDI is the Pharmacy Network. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$50 copayment retail $125 copayment mail order No deductible		Not Covered	
	Non-preferred brand drugs	$80 copayment retail $200 copayment mail order No deductible		Not Covered	
	Specialty drugs	If you obtain specialty drugs from LDI Specialty Pharmacy and there is copay assistance you pay $0. If you obtain specialty drugs from LDI Specialty Pharmacy and there is not copay assistance, you are responsible for a maximum of $500/year. If you obtain specialty drugs from a source other that LDI Specialty Pharmacy you are responsible for any cost above the 30% paid by the Fund.			Specialty drugs must be filled through the Fund's exclusive Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$115 copayment and 20% coinsurance	$170 copayment and 30% coinsurance	Not Covered	———none———
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	———none———

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network or Out of Area Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room care	$115 copayment 20% coinsurance	$115 copayment 20% coinsurance	$115 copayment 20% coinsurance	———none———
	Emergency medical transportation	20% coinsurance No deductible	25% coinsurance No deductible	25% coinsurance No deductible	———none———
	Urgent care	$55 copayment 20% coinsurance No deductible	$85 copayment 30% coinsurance No deductible	$115 copayment 50% coinsurance No deductible	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	50% coinsurance	———none———
	Physician/surgeon fee	20% coinsurance	30% coinsurance	50% coinsurance	———none———
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$25 copayment/visit	$35 copayment/visit	50% coinsurance	———none———
	Inpatient services	20% coinsurance	30% coinsurance	50% coinsurance	———none———
If you are pregnant	Office visits	No Charge	No Charge	50% coinsurance	Pregnancy related charges are not covered for dependent children
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	50% coinsurance	———none———
	Rehabilitation services	20% coinsurance	30% coinsurance	50% coinsurance	No deductible for O/T and P/T
	Habilitation services	Not Covered	Not Covered	Not Covered	No coverage
	Skilled nursing care	20% coinsurance	30% coinsurance	50% coinsurance	Limited to 60 days per Calendar Year
	Durable medical equipment	20% coinsurance	30% coinsurance	50% coinsurance	Subject to separate deductible
	Hospice service	20% coinsurance No deductible	30% coinsurance No deductible	50% coinsurance No deductible	———none———
If your *child* needs dental or eye care	Children's eye exam	Coverage is limited to $60 and one exam/year			
	Children's glasses	Coverage is limited to $100 for frames and up to $100 for lenses for one pair of glasses **or** up to $170 for a 12-month supply of contacts/year			

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Network Provider	Your Cost If You Use a Tier 2 Network or Out of Area Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Children's dental check-up	No Charge	No Charge	20% coinsurance No deductible	Delta Dental Plan of Missouri is the dental provider network.

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.)

- Infertility Treatment, with the exception of surgery to open tubes closed due to disease - Drug therapy covered at 50% coinsurance with a $2,500 maximum.
- Habilitation Services
- Long Term Care
- Private Duty Nursing
- Routine Foot Care
- Acupuncture
- Cosmetic Surgery

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

- Chiropractic care – obtained from a participating provider
- Dental care (Adult)
- Hearing aids, limited to $1,000 per ear
- Non-emergency care when traveling outside the U.S.
- Routine vision care (Adult)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 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 Benefit Office at 314-652-8175.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 314-652-8175.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 314-652-8175.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 314-652-8175.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 314-652-8175.]

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** **$200**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$80
Coinsurance	$2,504
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,784**

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

- **The plan's overall deductible** **$200**
- **Specialist copayment** **$40**
- **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$160
Coinsurance	$1,408
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,768**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$200**
- **Specialist copayment** **$115**
- **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$115
Coinsurance	$317
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$632**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Benefit Office at 314-652-8175.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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