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?	$500 member/spouse $300 child $1,300 family maximum	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. Prescription Drug Coverage: $100 person/$300 family maximum	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?	Yes. $4,250 member/spouse $4,050 child Amounts include the deductible.	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.blueadvantagearkansas.com or call 1-888-872-2531 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 PPO Network 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	20% coinsurance	Not Covered	———none———
	Specialist visit	20% coinsurance	Not Covered	———none———
	Preventive care/screening/immunization	No Charge	Not Covered	Limited 1 per year on preventive care; colonoscopy limited to 1 per 5 years beginning at age 50.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	———none———
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	———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	20% coinsurance	20% coinsurance; Covered only while traveling if no network pharmacy is available.	Covers up to a 30-day supply at Envision retail pharmacies.
	Preferred brand drugs	20% coinsurance		
	Non-preferred brand drugs	20% coinsurance		
	Specialty drugs	If you obtain specialty medication from LDI Specialty Pharmacy and there is copay assist you pay $0. If you obtain specialty medication from LDI Specialty Pharmacy and there is not copay assistance, you are responsible for a maximum of $500/year. If you obtain specialty medication 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)	20% coinsurance	Not Covered	Hospital copay will not apply to outpatient surgery centers
	Physician/surgeon fees	20% coinsurance	Not Covered	———none———
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-Network providers covered only in emergencies
	Emergency medical transportation	20% coinsurance	20% coinsurance	———none———

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Urgent care	20% coinsurance	Not Covered	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	———none———
	Physician/surgeon fee	20% coinsurance	Not Covered	———none———
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% coinsurance	Not Covered	———none———
	Inpatient services	20% coinsurance	Not Covered	———none———
If you are pregnant	Office visits	No Charge	Not Covered	———none———
	Childbirth/delivery professional services	20% coinsurance	Not Covered	———none———
	Childbirth/delivery facility services	20% coinsurance	Not Covered	———none———
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	———none———
	Rehabilitation services	20% coinsurance	Not Covered	———none———
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	20% coinsurance	Not Covered	———none———
	Durable medical equipment	20% coinsurance	Not Covered	———none———
	Hospice service	20% coinsurance	Not Covered	Coverage is limited to 26 weeks.
If your *child* needs dental or eye care See you Summary Plan Description for adult benefits.	Eye exam	No Charge	No Charge	Coverage is limited to one exam per calendar year
	Glasses	No Charge	No Charge	Coverage is limited to one lens and frame benefit per calendar year.
	Dental check-up	20% coinsurance	20% coinsurance	———none———

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Habilitation Services
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Dental care (adult)
- TMJ limited to $750 per course of treatment
- 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	$500
Specialist copayment	$0
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	$500
Copayments	$0
Coinsurance	$2,460
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,960

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

The plan's overall deductible	$500
Specialist copayment	$0
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*	$500
Copayments	$0
Coinsurance	$1,380
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,880

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

The plan's overall deductible	$500
Specialist copayment	$0
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*	$500
Copayments	$0
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$780

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