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 http://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?	No.	This plan does not have other deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical: $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.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 need immediate medical attention	Emergency room care	$115 copayment 20% coinsurance	$115 copayment 20% coinsurance	Non-Network providers covered only in emergencies
	Emergency medical transportation	20% coinsurance	20% coinsurance	——none——
	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.**	Children's Eye exam	Coverage is limited to $60 maximum and one exam/year.		
	Children's Glasses	Coverage is limited to $150 for frames and up to $120 for lenses for one pair of glasses/year or up to $230 for a 12-month supply of contacts/year.		
	Children's Dental check-up	20% coinsurance	20% coinsurance	Delta Dental Plan is the dental provider network.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al (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]

[Vietnamese (CHÚ Ý): để nhận được hỗ trợ trong tiếng Tây Ban Nha, xin vui lòng gọi đến các (314) 652-8175]

[Serbo-Croatian (OBAVJEŠTENJE): Za pomoć na hrvatskom, nazovite (314) 652-8175]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.