
 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, contact BeneSys at 1-866-599-3176. 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 1-866-599-3176 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,100 per person/ \$2,200 per family (PPO); \$2,200 per person/ \$4,400 per family (Non-PPO).	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. Certain in-network office visits and in-network preventive care 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$4,000 per person/ \$8,000 per family (PPO); \$8,000 per person/ \$16,000 per family (Non-PPO).	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 ?	Morbid obesity payments, prescription drug copays, pre-certification penalties, premiums , balance-billing charges, and health care 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.anthem.com or call 1-800-810-2583 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.	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	\$20 copay /office visit; deductible does not apply	50% coinsurance	-----none-----**
	Specialist visit	30% coinsurance	50% coinsurance	Chiropractic treatments subject to utilization review after 26 visits.**
	Preventive care/screening/immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. 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)	30% coinsurance	50% coinsurance	Pre-certification required (\$250 penalty).**
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Pre-certification required (\$250 penalty).**
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Generic drugs	Lesser of \$10 or 20% coinsurance (retail); \$25 copay (mail)		\$3,350 per person/\$6,700 per family prescription drug out-of-pocket limits .** Retail prescriptions limited to 34-day supply; mail order prescriptions limited to 90-day supply.
	Preferred brand drugs	Greater of \$20 or 30% coinsurance (retail); \$45 copay (mail)		
	Non-preferred brand drugs	Greater of \$30 or 40% coinsurance (retail); \$70 copay (mail)		
	Specialty drugs	20% coinsurance (generic drugs) 30% coinsurance (preferred brand drugs) 40% coinsurance (non-preferred brand drugs)		Specialty drugs limited to 30-day supply and must be filled through EnvisionRx.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Pre-certification required (\$250 penalty).**
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	\$100 copay /emergency room visit; deductible does not apply	\$100 copay /emergency room visit; deductible does not apply	Copayment is waived if admitted to hospital or if emergency care is for accidental injury.** Coinsurance amounts apply after emergency room copayment for non-emergency care provided in emergency room.**
	Emergency medical transportation	30% coinsurance	50% coinsurance	Limited to two trips per confinement.**

* For more information about limitations and exceptions, see the plan or policy document at www.sheetmetalworkers33benefitfunds.org.

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)	
	Urgent care	\$20 copay /office visit; deductible does not apply	50% coinsurance	-----none-----**
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Pre-certification required (\$250 penalty)**
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	\$20 copay /office visit for services provided by primary care provider .**
	Inpatient services	30% coinsurance	50% coinsurance	-----none-----**
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services .**
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Must be provided by a qualified Home Health Care Agency and prescribed in writing by a Physician; pre-certification required (\$250 penalty).**
	Rehabilitation services	30% coinsurance	50% coinsurance	Pre-certification required (\$250 penalty).**
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	Care must be certified by a Physician and not for the purpose of custodial care; pre-certification required (\$250 penalty).**
	Durable medical equipment	30% coinsurance	50% coinsurance	Pre-certification required (\$250 penalty).**
	Hospice services	30% coinsurance	50% coinsurance	Patient's life expectancy must not exceed six months and care must be provided by a Hospice Organization (as defined by the Plan); pre-certification required (\$250 penalty).**
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	\$600/family calendar year limit (Option 1); \$1,200/family calendar year limit (Option 2).**
	Children's glasses	20% coinsurance	20% coinsurance	
	Children's dental check-up	20% coinsurance	20% coinsurance	\$2,000/family calendar year limit (Option 1); \$4,000/family calendar year limit (Option 2).**

**Amounts paid by the Participant for Internal Revenue Code Section 213(d) expenses may be reimbursed from the Participant's HRA.

* For more information about limitations and exceptions, see the plan or policy document at www.sheetmetalworkers33benefitfunds.org.

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 (unless as a result of an accidental injury)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss program

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

- Acupuncture
- Bariatric surgery (Must be 18 years of age and [pre-certification](#) required (\$250 penalty))
- Chiropractic care (subject to utilization review after 26 visits)
- Dental care (Adult) (**\$2,000**/family calendar year limit under Option 1; **\$4,000**/family calendar year limit under Option 2)
- Hearing aids (50% [coinsurance](#) for all services, exams, fittings and appliances up to **\$2,500** every three years)
- Private-duty nursing ([pre-certification](#) required (\$250 penalty))
- Routine eye care (Adult) (**\$600**/family calendar year limit under Option 1; **\$1,200**/family calendar year limit under Option 2)
- Routine foot care

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: 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 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 BeneSys at 1-866-599-3176. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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](#).

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

* For more information about limitations and exceptions, see the plan or policy document at www.sheetmetalworkers33benefitfunds.org.

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](#) \$1,100
- [Specialist](#) [coinsurance](#) 30%
- [Hospital \(facility\)](#) [coinsurance](#) 30%
- [Other](#) [coinsurance](#) 30%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$0
Coinsurance	\$3,510
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$4,610

Note: These numbers do not consider any possible reimbursement from your HRA.

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

- The [plan's](#) overall [deductible](#) \$1,100
- [Specialist](#) [coinsurance](#) 30%
- [Hospital \(facility\)](#) [coinsurance](#) 30%
- [Other](#) [coinsurance](#) 30%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$20
Coinsurance	\$1,890
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,010

Note: These numbers do not consider any possible reimbursement from your HRA.

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

- The [plan's](#) overall [deductible](#) \$1,100
- [Specialist](#) [coinsurance](#) 30%
- [Hospital \(facility\)](#) [coinsurance](#) 30%
- [Other](#) [coinsurance](#) 30%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$0
Coinsurance	\$110
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,210

Note: These numbers do not consider any possible reimbursement from your HRA.