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.smwyoungstownbenefits.org or call 1-330-779-8863. 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.smwyoungstownbenefits.org or call 1-330-779-8863 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $400 person/$800 family; Out-of-Network: $800 person/$1,600 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 services, dental and vision 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.
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?	In-Network $1,500 person/ $3,000 family; Out-of-Network $3,000 person/$6,000 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?	Premiums, dental and vision coinsurance, balance-billing charges, and health care this plan does not 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.supermednetwork.com or call 1-800-601-9208 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
		In-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% coinsurance	30% coinsurance	None
	Specialist visit	20% coinsurance	30% coinsurance	Spinal manipulations limited to $1,000 per person per calendar year.
	Preventive care/screening/ immunization	No charge up to $150 (per person per calendar year) then 20% coinsurance. Deductible does not apply.	No charge up to $150 then 20% coinsurance. Deductible does not apply.	Includes routine physical exam, mammogram, hearing tests, PAP tests, and pediatric immunizations between ages 1 and 15.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com.	Generic drugs	10% coinsurance (retail and mail order) with a $10 copayment/fill minimum fill requirement.	10% coinsurance (retail) with a $10 copayment/fill minimum fill requirement.	30-day supply or 100 units whichever one is greater for retail. 90-day mail order supply. Mandatory mail order for maintenance medication after 3 retail fills.
	Brand drugs	25% coinsurance (retail & mail order) with a $25 copayment/fill minimum fill requirement. If a generic is available, you pay the difference in cost between the brand and generic plus the brand coinsurance, unless your physician has indicated that the brand should be "dispensed as written."	25% coinsurance (retail) with a $25 copayment/fill minimum fill requirement. If a generic is available, you pay the difference in cost between the brand and generic plus the brand coinsurance, unless your physician has indicated that the brand should be "dispensed as written."	
	Specialty drugs	25% coinsurance (retail and mail order)	25% coinsurance (retail)	Limited to designated drugs. Mandatory mail order for maintenance medication after 3 retail fills.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance after the In-Network deductible.	Out-of-Network emergency room care is covered at the In-Network rate.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance after the In-Network deductible.	Semi-private room rates covered. Private room covered at hospital's average semi-private room rate if hospital has no semi-private rooms available.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	None
	Inpatient services	20% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	Newborn care and hospital stay not covered for a dependent's child.
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Limited to $10,000 maximum per person per calendar year.
	Rehabilitation services	20% coinsurance	30% coinsurance	None
	Habilitation services	20% coinsurance	30% coinsurance	None
	Skilled nursing care	20% coinsurance	30% coinsurance	None
	Durable medical equipment	20% coinsurance	30% coinsurance	Rentals limited to purchase price of equipment.
	Hospice services	No charge up to $5,000, then 20% coinsurance	No charge up to $5,000, then 30% coinsurance	Requires written certification of terminal illness with a life expectancy of six months or less. Inpatient stay limited to 30 days, including respite care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	20% coinsurance. Deductible does not apply.	20% coinsurance. Deductible does not apply.	Benefits limited to $250 per person per calendar year.
	Children's glasses	20% coinsurance. Deductible does not apply.	20% coinsurance. Deductible does not apply.	
	Children's dental check-up	20% coinsurance. Deductible does not apply.	20% coinsurance. Deductible does not apply.	Coverage limited to $1,000 per family per calendar year.

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
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- 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.)

- Chiropractic care
- Dental care (Adult) ($1,000 annual limit per family)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (for emergency care)
- Routine eye care (Adult) ($250 calendar year limit per person)

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 U.S. Department of Labor, 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: the Plan Administrator, Sheet Metal Workers Local No. 33, 33 Fitch Boulevard, Austintown, OH, 1-330-779-8863. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebas/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.

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	$400
Specialist coinsurance	20%
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	$400
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,560

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

The plan's overall deductible	$400
Specialist coinsurance	20%
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	$400
Copayments	$0
Coinsurance	$1,670
What isn't covered	
Limits or exclusions	$420
The total Joe would pay is	$2,490

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

The plan's overall deductible	$400
Specialist coinsurance	20%
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	$400
Copayments	$0
Coinsurance	$310
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$710

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