This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.sm73funds.org or by calling 1-708-449-7373.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	**$0**	See the Chart starting on page 2 for your costs for services this plan covers.
Are there other **deductibles** for specific services?	Yes. **$50** for dental benefits per person **$50** for prescription drugs per person. There are no other specific **deductibles**.	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.
Is there an **out–of–pocket limit** on my expenses?	Yes. **$2,000** individual for prescription drugs **$4,000** family for prescription drugs	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out–of–pocket limit**?	Premiums, balance billed charges, health care this plan does not cover and **deductibles**.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of participating providers, visit www.deltadental.com or call 1-800-524-0149 or call the Fund Office at 1-708-449-7373.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a **specialist**?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a PPO Provider		Your cost if you use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Specialist visit	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Other practitioner office visit	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Preventive care/screening/immunization	Not covered.		Not covered.	Employee plus spouse have wellness benefit covering certain services at 100% (no co-insurance or deductible).
If you have a test	Diagnostic test (x-ray, blood work)	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Imaging (CT/PET scans, MRIs)	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-855-577-		**Retail**	**Mail**	**Non-Participating pharmacy**	**$50** deductible per person applies. **$2,000** individual out-of-pocket. **$4,000** family out-of-pocket.
	Generic drugs	30% co-insurance	30% co-insurance	30% co-insurance	Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Preferred brand drugs (Single Source)	30% co-insurance	30% co-insurance	30% co-insurance	If generic is available and brand name is preferred, 35% co-insurance applies instead. Non-PPO (non-participating

Common Medical Event	Services You May Need	Your cost if you use a PPO Provider		Your cost if you use a Non-PPO Provider	Limitations & Exceptions
6319 or by visiting www.optum.com/optumrx.html					pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Non-preferred brand drugs (Multi-brand source)	30% co-insurance	30% co-insurance	30% co-insurance	Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Specialty drugs	30% co-insurance	30% co-insurance	30% co-insurance	Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Physician/surgeon fees	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
If you need immediate medical attention	Emergency room services	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Emergency medical transportation	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Urgent care	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Physician/surgeon fee	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Mental/Behavioral health inpatient services	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Substance use disorder outpatient services	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
	Substance use disorder inpatient services	Not covered.		Not covered.	Services under Hospice Care Program (covered 100%).
If you are pregnant	Prenatal and postnatal care	Not covered.		Not covered.	Not covered.

Common Medical Event	Services You May Need	Your cost if you use a PPO Provider	Your cost if you use a Non-PPO Provider	Limitations & Exceptions
	Delivery and all inpatient services	Not covered.	Not covered.	Not covered.
If you need help recovering or have other special health needs	Home health care	Not covered.	Not covered.	Services under Hospice Care Program (covered 100%).
	Rehabilitation services	Not covered.	Not covered.	Services under Hospice Care Program (covered 100%).
	Habilitation services	Not covered.	Not covered.	Services under Hospice Care Program (covered 100%).
	Skilled nursing care	Not covered.	Not covered.	Services under Hospice Care Program (covered 100%).
	Durable medical equipment	Not covered.	Not covered.	Services under Hospice Care Program (covered 100%).
	Hospice service	No cost.	No cost.	No deductible or co-payment applies. 16-day limit for inpatient and 80-day limit for outpatient.
If your child needs dental or eye care	Eye exam	No cost.	No charge up to $50.	Not subject to deductible.
	Glasses	No charge up to $425.	No charge up to $250.	Not subject to deductible.
	Dental check-up	No cost.	No cost.	Preventive services at no-cost. Basic services at 60% co-insurance. Major services at 75% co-insurance. Anesthesia 75% co-insurance. $50 deductible per year applies. Benefit limited to $1,500 per year per person.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture
- Bariatric Surgery
- Chiropractor care
- Cosmetic Surgery
- Genetic Testing
- Habilitation Services
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing (unless medically necessary)
- Routine foot care
- Speech therapy
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Dental Care (Adult)
- Hearing Aids (up to $1,250 per device)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-708-449-7373. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Sheet Metal Workers' Local No. 73 Welfare Fund, 4530 Roosevelt Road, Hillside IL 60162, 708-449-7373, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance 100 Randolph St. 9th Floor, Chicago IL 60601, 877-527-9431, http://www.insurance.illinois.gov, or DOI.Director@illinois.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does not provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $20
- **Patient pays** $7,520

Sample care costs:

Item	Cost
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Item	Cost
Deductibles	$20
Copays	$0
Coinsurance	$0
Limits or exclusions	$7,500
Total	**$7,520**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $250
- **Patient pays** $5,150

Sample care costs:

Item	Cost
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Item	Cost
Deductibles	$50
Copays	$0
Coinsurance	$700
Limits or exclusions	$4,400
Total	**$5,150**

NOTE: If you are enrolled in the SMW+ plan, you may have additional coverage under that plan.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.