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, call 1-708-449-7373. 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 1-708-449-7373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$350** individual **$1,050** family (maximum of 3 individual deductibles per family per calendar year)	Generally, you must pay all of the costs from **providers** up to the **deductible** 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. For employees and spouses participating in the wellness benefit and for enrollees in the **plan's** disease management program.	This **plan** covers some items and services even if you haven't met the **deductible** amount. But a **copayment** or **coinsurance** may apply.
Are there other deductibles for specific services?	Yes. **$50** for dental benefits per person and **$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.
What is the out-of-pocket limit for this plan?	**$2,000** per individual for PPO medical. **$2,000** individual prescription drugs. **$4,000** family prescription drugs.	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**, the overall family **out-of-pocket limit** must be met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance billing**, health care services this **plan** does not cover, **deductibles**, covered services at non-PPO hospitals and ambulatory surgical facilities or by non-PPO physicians, and **copayments** for failure to obtain **preauthorization** for certain services.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.

Will you pay less if you use a network provider?	Yes. For a list of participating providers, visit www.bcbsil.com or call 1-800-810-BLUE (2583) or call the Fund Office at 1-708-449-7373.	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 do not need a referral to see a **specialist.**	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	15% co-insurance	30% co-insurance	None
	Specialist visit	15% co-insurance	30% co-insurance	**Coinsurance** does not apply to services under Hospice Care Program (covered 100%).
	Preventive care/screening/ Immunization	15% co-insurance	30% co-insurance	Immunizations are not covered for employee and spouse. Employee plus spouse have wellness benefit covering certain services at 100% (no **deductible** or **coinsurance**).
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance (in facility) 15% co-insurance (in physician's office)	30% co-insurance	**Coinsurance** does not apply to services under Hospice Care Program (covered 100%).
	Imaging (CT/PET scans, MRIs)	20% co-insurance (in facility) 15% co-insurance (in physician's office)	30% co-insurance	**Coinsurance** does not apply to services under Hospice Care Program (covered 100%).

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-855-577-6319 or by visiting www.optum.com /optumrx.html.	Generic drugs	30% co-insurance (Retail) 30% co-insurance (Mail)	30% co-insurance	Retail prescription covers up to 34-day supply; mail order prescription covers up to 31-90 day supply. Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Brand drugs (when no generic available)	30% co-insurance (Retail) 30% co-insurance (Mail)	30% co-insurance	
	Brand drugs (when generic is available)	35% co-insurance (Retail) 35% co-insurance (Mail)	35% co-insurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	30% co-insurance	None
	Physician/surgeon fees	15% co-insurance	30% co-insurance	**Coinsurance** does not apply to services under Hospice Care Program (covered 100%).
If you need immediate medical attention	Emergency room care	20% co-insurance (facility) 15% co-insurance (physician)	20% co-insurance (30% if non-emergency)	None
	Emergency medical transportation	20% co-insurance	20% co-insurance	None
	Urgent care	20% co-insurance (facility) 15% co-insurance (physician)	30% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	30% co-insurance	Additional $250 co-pay applies if you do not obtain **preauthorization**. Private room covered only if semi-private not available.
	Physician/surgeon fees	15% co-insurance	30% co-insurance	**Coinsurance** does not apply to services under Hospice Care Program (covered 100%).

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 need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance (facility) 15% co-insurance (physician)	30% co-insurance	None
	Inpatient services	20% co-insurance (facility) 15% co-insurance (physician)	30% co-insurance	None
If you are pregnant	Office visits	15% co-insurance	30% co-insurance	Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	15% co-insurance	30% co-insurance	None
	Childbirth/delivery facility services	20% co-insurance	30% co-insurance	None
If you need help recovering or have other special health needs	Home health care	15% co-insurance	20% co-insurance	None
	Rehabilitation services	20% co-insurance (facility) 15% co-insurance (physician)	30% co-insurance	Rehabilitative speech therapy to restore normal speech only if lost due to stroke or injury. Speech therapy for functional purposes is not covered.
	Habilitation services	Not covered.	Not covered.	Not covered.
	Skilled nursing care	20% co-insurance (facility) 15% co-insurance (physician)	Not covered.	Pre-certification of PPO in-network status required. **Coinsurance** does not apply to services under Hospice Care Program (covered 100%).
	Durable medical equipment	20% co-insurance	20% co-insurance	**Coinsurance** does not apply to services under Hospice Care Program (covered 100%).
	Hospice services	No charge	No charge	No **deductible** or **copayment** applies. 16-day limit for inpatient and 80-day limit for out-patient.
If your child needs dental or eye care	Children's eye exam	No charge	No charge up to $50	Not subject to **deductible**.
	Children's glasses	No charge up to $425	No charge up to $250	Not subject to **deductible**.
	Children's dental check-up	No charge	No charge	Preventive services at no-cost. Basic services

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)	
				60% **coinsurance**. Major services 75% **coinsurance**. Anesthesia 75% **coinsurance**. $50 **deductible** per year applies. Benefit limited to $1,500 per year per person.

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
- Genetic Testing
- Habilitation Services
- Long Term Care
- Routine foot care
- Speech therapy (for functional purposes including but not limited to: stuttering, stammering and conditions of psychoneurotic origin, or for developmental speech delays).
- Weight loss programs

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

- Acupuncture (if performed by licensed physician and for medical reasons only)
- Bariatric Surgery (subject to certain conditions)
- Chiropractor care (up to 20 visits per calendar year)
- Dental Care (Adult)
- Hearing Aids (up to $1,250 per device)
- Infertility Treatment (50% co-insurance up to $20,000 per couple per lifetime for treatments to promote conception)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (if medically necessary)
- Routine eye 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 provides 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 at Sheet Metal Workers' Local No. 73 Welfare Fund, 4530 Roosevelt Road, Hillside, IL 60162 or by phone at 1-708-449-7373 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 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-708-449-2122.

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	$350
Specialist copayment	$0
Hospital (facility) coinsurance	20%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$386
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$700
The total Peg would pay is	**$3,086**

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

The plan's overall deductible	$350
Specialist copayment	$0
Hospital (facility) coinsurance	20%
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$400
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$300
The total Joe would pay is	**$2,500**

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

The plan's overall deductible	$350
Specialist copayment	$0
Hospital (facility) coinsurance	20%
Other coinsurance	15%

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	$350
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

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 plan at 1-708-449-7373.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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