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?	**$250** individual **$750** family (maximum of 3 individual deductibles per family per calendar year)	You must pay all the costs up to the **deductible** before this plan begins to pay for the covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. For employees and spouses under the Plan's Wellness Benefit and for Enrollees in the MCM Disease Management Program.	Employees and spouses are entitled to certain routine services to maintain wellness under the plan's Wellness Benefit. Employees and spouses with Cardiovascular and/or Diabetes may enroll in the MCM Disease Management Program. Both the Wellness Benefit and MCM Disease Management Program cover certain services without deductibles or copayments.
Are there other deductibles for specific services?	Yes. **$25** for prescription drugs per family. 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?	**$1,250** per individual for PPO medical.	The out-of-pocket limit is the most you could pay during a covered 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 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**.

[* For more information about limitations and exceptions, see the plan or policy document at www.sm73funds.org]

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.	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 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 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	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	Co-insurance 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 co-insurance).
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance (facility) 15% co-insurance (physician's office)	30% co-insurance	Co-insurance does not apply to services under Hospice Care Program (covered 100%).
	Imaging (CT/PET scans, MRIs)	20% co-insurance (facility) 15% co-insurance (physician's office)	30% co-insurance	Co-insurance 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 www.optum.com/optumrx.html.	Generic drugs	Retail: 10% co-insurance, $5 minimum Mail: 10% co-insurance, $10 minimum	10% co-insurance	Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Preferred brand drugs	Retail: 20% co-insurance, $15 if no generic available Mail: 20% co-insurance, $30 minimum if no generic available	20% co-insurance	If generic is available and brand name is preferred, 30% co-insurance applies instead and minimums and maximums as noted. Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Non-preferred brand drugs	Retail: 30% co-insurance, $25 minimum, $50 maximum Mail: 30% co-insurance, $50 minimum, $100 maximum	30% co-insurance	If generic is available and brand name is preferred, 30% co-insurance applies instead and minimums and maximums as noted. Non-PPO (non-participating pharmacy) purchases are reimbursed at the negotiated pharmacy rates.
	Specialty drugs	Retail: Generic 10% co-insurance, $5 minimum, Preferred Brand 20% co-insurance, $25 minimum, $50 maximum Mail: Generic 10% co-insurance ($10 minimum, Preferred Brand 20% coinsurance, ($50 minimum $100 maximum)	30% co-insurance	If generic is available and brand name is preferred, 30% co-insurance applies instead and minimums and maximums as noted. 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)	20% co-insurance	30% co-insurance	None.
	Physician/surgeon fees	15% co-insurance	30% co-insurance	Co-insurance 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 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 pre-authorization. Private room covered only if semi-private not available.
	Physician/surgeon fees	15% co-insurance	30% co-insurance	Co-insurance does not apply to services under Hospice Care Program (covered 100%).
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	None.
	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. For functional purposes not covered. Co-insurance 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)	
	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. Co-insurance does not apply to services under Hospice Care Program (covered 100%).
	Durable medical equipment	20% co-insurance	20% co-insurance	Co-insurance does not apply to services under Hospice Care Program (covered 100%).
	Hospice services	No cost	No cost	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 cost	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	Not Covered.	Not Covered.	Not Covered.

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Genetic Testing
- Habilitation Services
- Long Term Care
- Private-duty nursing (unless medically necessary)
- 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)
- Chiropractor care (up to 20 visits per calendar year)
- 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.
- Routine eye care (Adult)

[* For more information about limitations and exceptions, see the plan or policy document at www.sm73funds.org]

For more information on your rights to continue coverage, contact the plan at 1-707-449-7373. 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 Humans Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

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: [insert applicable contact information from instructions].

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 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].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-708-449-2122].]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [1.708.449.2122.]]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [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** **$**
- **Specialist *[cost sharing]*** **$**
- **Hospital (facility) *[cost sharing]*** **%**
- **Other *[cost sharing]*** **%**

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	**$**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$**

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

- **The plan's overall deductible** **$**
- **Specialist *[cost sharing]*** **$**
- **Hospital (facility) *[cost sharing]*** **%**
- **Other *[cost sharing]*** **%**

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	**$**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$**

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

- **The plan's overall deductible** **$**
- **Specialist *[cost sharing]*** **$**
- **Hospital (facility) *[cost sharing]*** **%**
- **Other *[cost sharing]*** **%**

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	**$**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$**

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