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, please call (618) 397-1443. 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.healthcare.gov/sbc-glossary/ or call 1-800-343-3140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 individual / $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. For Participating Providers only: preventive services, inpatient hospital facility charges, outpatient hospital facility charges, outpatient emergency room facility charges, urgent care, physician office visits, mental health, and substance abuse services.	This plan covers some items and services even if you have not yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Participating Providers: $650 individual / $1,300 family; for Out-of-Network/Non-Participating Providers: $3,900 individual / $7,800 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, balanced-billed charges, healthcare this plan does not cover, copayments, deductibles, and cost containment penalties.	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. See www.aetna.com/docfind/custom/mymeritain/ or call 1-800-343-3140 for a list of Network Providers.	You pay the least if you use a Participating provider. You will pay the most if you use an Out-of-Network/Non-Participating 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 Participating Provider may use an Out-of-Network/Non-

		Participating 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
		Participating Provider (You will pay the least)	Out-of-Network/Non-Participating 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	$10 copayment, no deductible.	30% coinsurance.	None.
	Specialist visit	$10 copayment, no deductible. Chiropractor: 10% coinsurance.	30% coinsurance. Chiropractor: 30% coinsurance.	Chiropractic visits are limited to 24 per calendar year and chiropractic services are limited to spinal manipulation, diagnostic testing, and x-rays.
	Preventive care/screening/ immunization	$10 copayment, no deductible.	Not covered.	You may have to pay more for services that are not 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)	10% co-insurance.	30% co-insurance.	None.
	Imaging (CT/PET scans, MRIs)	10% co-insurance.	30% co-insurance.	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.castiarx.com	Generic drugs	$10 copayment (retail); $20 copayment (mail order).		Limited to 31-day supply (retail) and 90-day supply (mail order) The Prescription Drug Program is an independent program, separate from medical coverage, provided through CastiaRx. In order to receive the full benefit of the Prescription Drug Program, you must use participating pharmacies and present your CastiaRx card.
	Formulary drugs	$25 copayment (retail); $40 copayment (mail order).		
	Non-formulary brand drugs	$45 copayment (retail); $70 copayment (mail order).		
	Specialty drugs	The Plan will pay the first 50% of the cost of specialty drugs through CastiaRx's Specialty Pharmacy Program.		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Out-of-Network/Non-Participating Provider (You will pay the most)	
		CastiaRx will then assist you in applying for payment assistance. If payment from other sources is received, the plan will pay the remaining cost of the prescription after the third-party payments are applied with no amount due from you. If there is no payment available from other sources, you will only be responsible for the brand copayment amount as shown in the prescription drug schedule of benefits. Coupons, copayment assistance and other forms of financial assistance and any amounts not paid out of you or your dependent's "pocket" are not counted towards your out-of-pocket limit.		Monthly high-cost prescriptions that cost $2,000 or more must be preauthorized. Specialty drugs must be obtained from the Specialty Pharmacy Program after the prescription has been filled once at a retail pharmacy. Prescription Drugs with a cost of $5,000 or more are not covered unless medically necessary for the treatment of a life-threatening condition or because that drug is the sole available treatment for the applicable condition.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 copayment, 10% coinsurance, no deductible.	$75 copayment, 30% coinsurance.	None.
	Physician/surgeon fees	10% co-insurance.	30% co-insurance.	
If you need immediate medical attention	Emergency room care	$36 copayment, 10% coinsurance, no deductible.	$108 copayment, 30% coinsurance.	Copayment waived if admitted to hospital. $250 penalty for failure to notify if admitted.
	Emergency medical transportation	10% co-insurance.	30% co-insurance.	None.
	Urgent care	$10 copayment, no deductible.	30% co-insurance.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$50 copayment, 10% coinsurance, no deductible.	$100 copayment, 30% coinsurance.	Preauthorization is required or a penalty of $250 will apply. Semi-private room rate, unless semi-private room is not available, then private room rate.
	Physician/surgeon fees	10% co-insurance.	30% co-insurance.	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Out-of-Network/Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment for office visits. $25 copayment, 10% coinsurance for outpatient services. No deductible.	30% coinsurance for office visits. $75 copayment, 30% coinsurance for outpatient services.	None.
	Inpatient services	$50 copayment, 10% coinsurance.	$100 copayment, 30% coinsurance.	Preauthorization is required or a penalty of $250 will apply. If an emergency, within 48-hours of admission; if a non-emergency, 48-hours advance notice required. Semi-private room rate, unless semi-private room is not available, then private room rate.
If you are pregnant	Office visits	$10 copayment, no deductible.	30% coinsurance.	None.
	Childbirth/delivery professional services	10% co-insurance.	30% co-insurance.	
	Childbirth/delivery facility services	Hospital: $50 copayment, 10% coinsurance; Birthing Center: 10% coinsurance.	Hospital: $100 copayment, 30% coinsurance; Birthing Center: 30% coinsurance.	
If you need help recovering or have other special health needs	Home health care	10% co-insurance.	30% co-insurance.	Limited to maximum of 100 visits/calendar year, up to four hours equals one visit.
	Rehabilitation services	10% co-insurance.	30% co-insurance.	Limited to 120 days/calendar year for inpatient and outpatient occupational and physical therapy, and 50 days/calendar year for speech therapy.
	Habilitation services	Not covered.	Not covered.	
	Skilled nursing care	10% co-insurance.	30% co-insurance.	48-hour advance preauthorization is required or a penalty of $250 will apply. Limited to 90 days/calendar year for the same or related causes.
	Durable medical equipment	10% co-insurance.	30% co-insurance.	Prosthetics and orthotics are covered for the initial equipment only, not replacements.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Out-of-Network/Non-Participating Provider (You will pay the most)	
	Hospice services	10% co-insurance.	30% co-insurance.	185-day outpatient care lifetime maximum, all network levels combined.
If your child needs dental or eye care	Children's eye exam	Not Covered.		
	Children's glasses	Not Covered.		
	Children's dental check-up	Not Covered.		

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult), with certain exceptions
- Gene Therapy Treatment
- Habilitation services
- Hearing aids, unless loss of hearing is due to a covered injury or illness
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Prescription Drugs with a cost of $5,000 or more, unless medically necessary for the treatment of a life-threatening condition or because that drug is the sole available treatment for the applicable condition.
- Routine foot care, with certain exceptions
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery, if medically necessary for surgical treatment of morbid obesity
- Chiropractic care, maximum 24 visits/calendar year and limited to spinal manipulation, diagnostic testing, and x-rays
- COVID-19 Testing and Initial Medical visit to be Tested
- Long-Term Care, as covered by skilled nursing benefit; preauthorization required
- Private-duty nursing (subject to limitations; consult your plan document for more information)

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 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: 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: Board of Trustees of the Sheet Metal Workers, Local Union 268 Welfare Plan, 2701 North 89th Street, Caseyville, Illinois 62232, 618-397-1443.

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: 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, Illinois 60601, 1-877-527-9431, or visit the website at www.insurance.illinois.gov, or email 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 1-314-865-1300
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-314-865-1300
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-314-865-1300
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-314-865-1300

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	$300
Specialist copayment	$10
Hospital (facility) copayment	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$300
Copayments	$180
Coinsurance	$650
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,190

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

The plan's overall deductible	$300
Specialist copayment	$10
Hospital (facility) copayment	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$300
Copayments	$775
Coinsurance	$186
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,316

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

The plan's overall deductible	$300
Specialist copayment	$10
Hospital (facility) copayment	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$300
Copayments	$65
Coinsurance	$168
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$533

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

Addendum

Section 1557 Nondiscrimination Notice

The Sheet Metal Workers Local Union 268 Welfare Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Sheet Metal Workers Local Union 268 Welfare Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Sheet Metal Workers Local Union 268 Welfare Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters, and
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters, and
  - Information written in other languages.

If you need these services, contact:

Rhonda Cresswell
Benefit Coordinator
2701 North 89th Street, Caseyville, IL 62232
Phone: (618) 397-1443
Fax: (618) 397-3204
smwlocal268@sbcglobal.net

If you believe that the Sheet Metal Workers Local Union 268 Welfare Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Rhonda Cresswell
Benefit Coordinator
2701 North 89th Street, Caseyville, IL 62232
Phone: (618) 397-1443
Fax: (618) 397-3204
smwlocal268@sbcglobal.net

You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, Managing Trustee Jeff Bauer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at: *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537 7697(TDD).Complaint forms are available at: *http://www.hhs.gov/ocr/office/file/index.html.*

Section 1557 Required Language Taglines

- (English) ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-618-397-1443.
- (Spanish) ATENCIÓN: si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-618-397-1443.
- (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-618-397-1443.
- (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-618-397-1443.
- (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-618-397-1443.
- (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-618-397-1443.
- (Serbo-Croatian) OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-618-397-1443.
- (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-618-397-1443. 번으로 전화해 주십시오.
- (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-618-397-1443.
- (Arabic) 1-618-397-1443.اتصل برقم .ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان
- (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-618-397-1443.
- (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-618-397-1443.
- (Pennsylvania Dutch) Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-618-397-1443.
- (Hindi) ध्यान द: यद आप हदी बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-1-618-397-1443. पर कॉल कर।
- Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-618-397-1443.まで、お電話にてご連絡ください。
- Persian **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-618-397-1443.فراهم می باشد. با تماس بگیرید
- (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-618-397-1443.کر
- (Gujarathi) ચુના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-618-397-1443.
- (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-618-397-1443.
- (Dutch) AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-618-397-1443.
- (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε1-618-397-1443.