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: Unlimited.	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.	
	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.	
	Imaging (CT/PET scans, MRIs)	10% co-insurance.	30% co-insurance.	Preauthorization is required.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.citizensrx.com	Generic drugs	$10 copayment (retail); $20 copayment (mail order).		Limited to 31-day supply or 90-day supply for maintenance medications. The Prescription Drug Program is an independent program, separate from medical coverage, provided through CitizensRx. In order to receive the full benefit of the Prescription Drug Program, you must use participating pharmacies and present your CitizensRx card. 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 excluded from coverage, unless medically necessary for the treatment of a life-threatening condition or because that drug is the sole available treatment for the applicable condition. Monthly high-cost prescription drugs (costing $2,000 or more) which are to be covered under the medical benefit provisions of the plan must be preauthorized.
	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 CitizensRx's Specialty Pharmacy Program. CitizensRx 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.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 copayment, 10% coinsurance, no deductible.	$75 copayment, 30% coinsurance.	Preauthorization is required for certain surgeries.
	Physician/surgeon fees	10% co-insurance.	30% co-insurance.	

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 immediate medical attention	Emergency room care	$36 copayment, 10% coinsurance, no deductible.	$36 copayment, 10% coinsurance, no deductible.	Copayment waived if admitted to hospital. Benefits for Emergency Services provided at an out-of-network facility will be paid at the participating provider cost-sharing level to the extent required by the No Surprises Act.
	Emergency medical transportation	10% co-insurance.	Ground Ambulance - 30% of up to 300% of Medicare Allowable Rate co-insurance. Air Ambulance – 10% co-insurance.	None.
	Urgent care	$10 copayment, no deductible.	30% co-insurance.	
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. 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.
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. 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.

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 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.	Preauthorization is required. Limited to maximum of 100 visits/calendar year, up to four hours equals one visit.
	Rehabilitation services	10% co-insurance.	30% co-insurance.	Preauthorization is required for inpatient services. 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.	Preauthorization is required Limited to 90 days/calendar year for the same or related causes.
	Durable medical equipment	10% co-insurance.	30% co-insurance.	Preauthorization is required for certain devices. Prosthetics and orthotics are covered for the initial equipment only, not replacements.
	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.
- 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
- 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$650
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,090**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$980**

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	**$2,830**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$70
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$570**

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