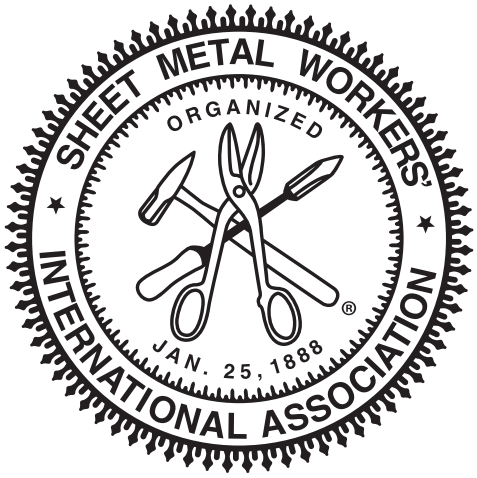

SHEET METAL WORKERS' LOCAL UNION NO. 80
INSURANCE TRUST FUND

SUMMARY OF BENEFITS AND COVERAGES 2021

(CONSTRUCTION EMPLOYEES, OWNER-MEMBER EMPLOYEES
AND
ALL RETIREES WHO ARE NOT MEDICARE-ELIGIBLE)

January 2021

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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, visit www.benesysinc.com/benefit/sheet80fringe.asp or by calling (248)641-4980 or (800)400-7710. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call (248)641-4980 or 800-400-7710 to request a copy. For information on dental or vision benefits, please contact the Fund Office at www.benesysinc.com/benefit/sheet80fringe.asp or by calling (248)641-4980 or (800)400-7710.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$400 Individual / $800 Family	$1,500 Individual / $3,000 Family	Generally, you must pay all 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	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment and coinsurance may apply.
Are there other deductibles for specific services?	No	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	"True" OOP max: $8,550 Individual / $17,100 Family Coinsurance max for medical benefits: $1,000 Individual / $2,000 Family	"True" OOP max: None. Coinsurance max for medical benefits: $4,500 Individual / $9,000 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?	"True" OOP max: premiums, balance-billed charges, and health care this plan doesn't cover. Coinsurance max for medical benefits: fixed dollar and private duty nursing copayments, deductibles, premiums, balance-billed charges, and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes	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-pocket 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 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	$25 co-pay	50% co-insurance after deductible	Chiropractor office visit: $25 co-pay
	Specialist visit	$25 co-pay	50% co-insurance after deductible	
	Preventive care/screening/ immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	50% co-insurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	50% co-insurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com or call (800) 361-4542.	Generic drugs	$10 co-pay	$10 co-pay plus the difference between what an in-network pharmacy would have charged and what the out-of-network pharmacy actually charged.	For all in-network, non-specialty drugs, up to a 90 day supply is available for twice the copay amount by mail order. The Fund does **not** cover any prescriptions filled at Wal-Mart or Sam's Club. Envision Specialty Pharmacy or Costco Specialty Services must be used for all specialty drugs. Other limitations may apply – contact the Fund Office for details.
	Preferred brand drugs	$30 co-pay	$30 co-pay plus the difference between what an in-network pharmacy would have charged and what the out-of-network pharmacy actually charged.	
	Non-preferred brand drugs	$60 co-pay	$60 co-pay plus the difference between what an in-network pharmacy would have charged and what the out-of-network pharmacy actually charged.	

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)	
	Specialty drugs	$60 co-pay	$60 co-pay plus the difference between what an in-network pharmacy would have charged and what the out-of-network pharmacy actually charged.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	50% co-insurance after deductible	LASIK lifetime maximum per person of $900 per eye.
	Physician/surgeon fees	20% co-insurance after deductible	50% co-insurance after deductible	
If you need immediate medical attention	Emergency room care	$100 co-pay	$100 co-pay	Co-pay waived if admitted or for an accidental injury.
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	---none---
	Urgent care	$25 co-pay	50% co-insurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	50% co-insurance after deductible	---none---
	Physician/surgeon fees	20% co-insurance after deductible	50% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Mental Behavioral Health Outpatient services	20% co-insurance after deductible	20% co-insurance after deductible	If services rendered in an office setting, as opposed to a facility or clinic, out-of-network cost share is 50% co-insurance.
	Mental Behavioral Health Inpatient services	20% co-insurance after deductible	20% co-insurance after deductible	---none---
	Substance use disorder outpatient services	20% co-insurance after deductible	20% co-insurance after deductible	---none---
	Substance use disorder inpatient services	20% co-insurance after deductible	20% co-insurance after deductible	---none---
If you are pregnant	Office visits	No charge	50% co-insurance after deductible	Excludes laboratory or ultrasound benefits
	Childbirth/delivery professional services	20% co-insurance after deductible	50% co-insurance after deductible	---none---
	Childbirth/delivery facility services	20% co-insurance after deductible	50% co-insurance after deductible	---none---
If you need help recovering or have	Home health care	20% co-insurance after deductible	20% co-insurance after deductible	---none---

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)	
other special health needs	Rehabilitation services	20% co-insurance after deductible	50% co-insurance after deductible	Physical, occupational, and speech therapy is limited to a combined maximum of 60 visits per member per calendar year. Hearing care benefits are provided with no charge to the member if provided by an in-network provider.
	Habilitation services	Not covered	Not covered	---none---
	Skilled nursing care	20% co-insurance after deductible	20% co-insurance after deductible	Limited to a maximum of 120 days per member per calendar year
	Durable medical equipment	20% co-insurance after deductible	20% co-insurance after deductible	---none---
	Hospice services	No charge	No charge	Up to 28 pre-hospice counseling visits covered before electing services; when elected, four 90-day periods provided through a participating hospice program only.
If your child needs dental or eye care	Children's eye exam	$10 co-pay	$10 co-pay. The Plan pays up to $45 for an exam, you are responsible for the balance.	Eye exams must be provided by an optometrist and are limited to once per calendar year.
	Children's glasses	$25 co-pay Plan covers up to: $130 for Basic Frame $150 for Brand Frame PLUS 20% discount on amounts over the allowance; Single Vision, Lined Bifocal, Lined Trifocal and Lenticular: covered 100% Lense Enhancements; Standard Progressive covered up to $55; Premium Progressive:	$25 co-pay Frames covered up to $70. Single Vision: covered up to $30; Lined Bifocal covered up to $50; Lined Trifocal covered up to $65; and Lenticular covered up to $100	Frames are limited to once per 24 months. Lenses are limited to once per 12 months. The Fund has discount agreements with three vision providers – VSP, SVS Vision, and Henry Ford OptimEyes. Contact the Fund Office for additional information.

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)	
		plan pays $95 - $105; Custom Progressive: plan pays $150 - $175 (avg. savings of 20-25% on amount over allowance.)		
	Children's dental check-up	No charge	20% co-insurance	Oral exams are limited to once per six-months and full mouth x-rays are limited to once per thirty-six months. Dental benefits limited to $1,500 per member per calendar year.

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.)

- Acupuncture
- Cosmetic surgery (except as required under the Women's' Health and Cancer Rights Act)
- Infertility treatment
- Long-term care
- Routine foot care

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

- Bariatric surgery (if pre-authorized)
- Chiropractic care
- Private-duty nursing
- Dental care (adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Weight loss programs (under certain circumstance if requirements are met)

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the Fund Office at 800-400-7710. There are agencies that can help if you want to continue your coverage after it ends. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 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 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: U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa.

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:

To get help reading in your language, call the customer service number on the back of your ID card.

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**	**$400**
■ **Specialist copayment**	**$25**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**N/A**

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	$400
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,400**

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

■ **The plan's overall deductible**	**$400**
■ **Specialist copayment**	**$25**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**N/A**

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	$660
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,360**

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

■ **The plan's overall deductible**	**$400**
■ **Specialist copayment**	**$25**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**N/A**

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	$400
Copayments	$100
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$580**

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

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SHEET METAL WORKERS' LOCAL
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Important Plan Information