



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

**SUMMARY OF BENEFITS AND COVERAGES 2021**

**(HMO PLAN FOR PRODUCTION RESIDENTIAL,  
LIGHT COMMERCIAL SERVICE, ARCHITECTURAL METAL,  
DUCT CLEANING, APPRENTICES, PROBATIONARY EMPLOYEES  
AND NON-MEDICARE-ELIGIBLE RETIREES)**

**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.bcbsm.com](http://www.bcbsm.com) or call (800)662-6667. 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](http://www.healthcare.gov/sbc-glossary) or call (800)662-6667 to request a copy. For information on dental or vision benefits, please contact the Fund Office at [www.benesysinc.com/benefit/sheet80fringe.asp](http://www.benesysinc.com/benefit/sheet80fringe.asp) or by calling (248)641-4980 or (800)400-7710.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall <u>deductible</u> ?	\$500 / \$1,000	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	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 <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,000 / \$4,000	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket</u> limits until the overall family <u>out-of-pocket</u> limit has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.bcbsm.com">www.bcbsm.com</a> or call the number on the back of your BCBSM ID card for a list of network providers.	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 <u>referral</u> to see a <u>specialist</u> ?	Yes, in-network only. Paper or electronic.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 co-pay / visit. Deductible does not apply	Not covered	---none---
	<u>Specialist</u> visit	\$20 co-pay / visit	Not covered	Requires referral. \$5 co-pay for allergy injections / 50% co-insurance for allergy office visit & testing /Deductible applies
	<u>Preventive care/screening/immunization</u>	No charge. Deductible does not apply	Not covered	---none---
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>co-insurance</u> . Lab services covered in full. Deductible does not apply to lab services	Not covered	May require prior authorization / No charge for lab services / Deductible applies except for lab service
	Imaging (CT/PET scans, MRIs)	20% co-insurance	Not covered	Requires prior authorization / Deductible applies
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.elixirsolutions.com">www.elixirsolutions.com</a> or call (800) 361-4542.	Tier 1- Formulary Preferred (Mostly Generic)	\$10 / Rx Retail or Mail. Deductible does not apply	Not covered	Prior authorization and step-therapy apply to selected drugs. 90-day retail co-pays are 2x the standard retail co-pays. 50% co-insurance for sexual dysfunction drugs. As of 1/1/2013, Tier 1 contraceptives are covered in full. Limited to a 30-day supply.
	Tier 2- Formulary Brand	\$20 / Rx Retail or Mail. Deductible does not apply	Not covered	
	Tier 3- Non-Formulary	\$40 / Rx Retail or Mail. Deductible does not apply	Not covered	
	<u>Specialty drugs</u>	Tiered co-pays listed above apply. Deductible does not apply	Not covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>co-insurance</u>	Not covered	May require prior authorization / 50% co-insurance for weight reduction procedures, pregnancy termination, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy / Deductible applies
	Physician/surgeon fees	20% co-insurance	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	<u>Emergency room care</u>	\$75 co-pay / visit	\$75 co-pay / visit	Co-pay waived if admitted / Deductible applies
	<u>Emergency medical transportation</u>	20% co-insurance	20% co-insurance	Non-emergent transport is not covered / Deductible applies
	<u>Urgent care</u>	\$50 co-pay / visit	\$50 co-pay / visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Not covered	Requires prior authorization / 50% co-insurance for weight reduction procedures, TMJ, pregnancy termination, orthognathic surgery, reduction mammoplasty, male mastectomy / Deductible applies
	Physician/surgeon fees	No charge	Not covered	See "Hospital stay facility fee"
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 co-pay / visit. Deductible does not apply	Not covered	Requires prior authorization / Deductible applies
	Inpatient services	20% <u>co-insurance</u>	Not covered	Requires prior authorization / Deductible applies
If you are pregnant	Office visits	No charge. Deductible does not apply	Not covered	Postnatal and non-routine prenatal office visits-\$30 co-pay / visit. Only the routine prenatal visit is exempt form the deductible. Other services, deductible applies
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	20% co-insurance	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	\$20 co-pay / visit	Not covered	Requires preauthorization. Custodial care not covered. Deductible applies
	<u>Rehabilitation services</u>	\$20 co-pay / visit	Not covered	Requires authorization / One period of treatment for any combination of therapies within 60 consecutive days per calendar year / 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)	
	<u>Habilitation services</u>	Not covered / ABA - \$20 co-pay / visit	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires prior authorization.
	<u>Skilled nursing care</u>	20% co-insurance	Not covered	Requires prior authorization / Limited to 45 days per calendar year/ Deductible applies. Custodial care not covered.
	<u>Durable medical equipment</u>	50% <u>co-insurance</u>	Not covered	Requires prior authorization and must be authorized and obtained from a BCN supplier. Convenience and comfort items not covered. Deductible does not apply to diabetic supplies.
	<u>Hospice services</u>	No charge	Not covered	Inpatient care requires authorization / Deductible applies. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	\$10 co-pay / Contact lens exam and fitting: up to \$60 copay	\$10 co-pay. The Plan pays up to \$45 for an exam, you are responsible for the balance.	Eye exams are limited to once per calendar year.
	Children's glasses	\$25 copay – includes frames, single lenses, bifocal lenses, trifocal lenses or lenticular and polycarbonate lenses for dependent children. Progressives: \$55 to \$175 co-pay Necessary Contacts: \$25	The Plan pays up to the following limits, you are responsible for the balance - Single lenses: \$30 Bifocal lenses: \$50 Trifocal lenses: \$65 Lenticular: \$100 Progressives: N/A Frames: \$70 Necessary Contacts: \$210	Frames are limited to once every other calendar year. \$130 basic frame allowance, \$150 preferred brand allowance; 20% savings on amount over allowance.  Lenses and enhancements are limited to once per calendar year.  Contact lenses are limited to once per calendar year  More information about <u>vision coverage</u> is available at <a href="http://www.vsp.com">www.vsp.com</a>

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)	
	Children's dental check-up	No charge	20% <u>co-insurance</u>	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)			
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Habilitation Services</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult)</li> <li>• Dental care (adult)</li> </ul>	

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information contact the Fund Office at (800) 400-7710, the state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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](http://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.

For more information about limitations and exceptions, contact the Fund Office at [www.benesysinc.com/benefits/sheet80fringe.asp](http://www.benesysinc.com/benefits/sheet80fringe.asp) or call (248) 641-4980.

**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 BCN 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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$1,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,060</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,060</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>

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

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**SHEET METAL WORKERS' LOCAL  
UNION NO. 80 FRINGE BENEFIT FUNDS  
P.O. BOX 1408  
TROY, MI 48099-1408**



## **Important Plan Information**

PRESORTED  
FIRST CLASS MAIL  
U.S. Postage  
**PAID**  
ABC Mailing, Inc.  
48083