

SUMMARY OF BENEFITS — ACTIVE BARGAINED, NON-BARGAINED EMPLOYEES, PRODUCTION WORKERS, PRE-MEDICARE-ELIGIBLE RETIREES AND THEIR ELIGIBLE DEPENDENTS

The following chart highlights key features of the Sheet Metal Workers Local Union No. 20 Welfare and Benefit Plan for Active Bargained, Production Workers, Pre-Medicare Retirees and Non-Bargained Employees and their eligible Dependents as of January 1, 2026.

Major Medical Benefits	Coverage
Coverage provided only for in-network services except in case of medical emergency.	
Annual Deductible¹	\$650 per person; \$1,625 per family
¹ In order to meet an in-network family deductible, one family member must satisfy the applicable individual (per person) deductible.	
Out-of-Pocket Maximum² (includes deductible)	\$7,500 per person; \$15,000 per family Combined Medical and Rx Out-of-Pocket Maximum
² The out-of-pocket maximum includes the annual deductible, ER deductible, coinsurance, and prescription drug expenses. However, this maximum does not include any expenses for chiropractic charges or any expenses over the scheduled or limited amounts specified by the Plan. Out-of-pocket maximum may increase annually with statutory limit. There is no out-of-pocket maximum for out-of-network expenses.	
Coinsurance³	Plan covers 80% in network
³ Unless specifically stated otherwise, the Plan covers 80% of major medical covered expenses after the deductible is satisfied (including covered expenses not listed on this "Summary of Benefits").	
Hospital and Physician Services and Supplies	80%
Emergency Room Services	80% (additional \$250 copay for each visit after the first, if not admitted to the hospital.)
Emergency Medical Transportation/Ambulance	80%
Second Surgical Opinion	80%
Vasectomy	100%
Laser Eye Surgery	Plan covers 100% up to \$4,000 per eye
Manual Manipulation and Subluxation of the Spine	Plan covers 80% up to \$1,000 per person per year
Outpatient Mental and Nervous Disorders	80%
Substance Use Disorder Treatment Benefits	80%
Diagnostic Imaging Test (such as an MRI, CT scan, or PET scan)	80%
Wellness Benefits	Coverage
Routine Physical Exam (one per year)	100%, no deductible
Well-Child Care	Plan covers, up to age 18: 100%, no deductible
Preventive Care, including Well-Woman Care, Adult Vaccination (FDA approved vaccinations), Prescription Contraceptives for Females, and Colonoscopies as required under the Affordable Care Act (ACA)	100%, no deductible
Smoking Cessation Benefit ⁴	Plan covers 100%, no copay or deductible; two (2) cycles of treatment per year.
⁴ Includes over-the-counter (OTC) aids that promote smoking cessation, and hypnosis therapy and laser treatments performed by an Anthem BlueCross BlueShield PPO network provider. Your Physician must write you a prescription for any medication and treatment, including an OTC aid, in order for it to be covered under the Plan.	
Health club or fitness dues ⁵	100%, no deductible
⁵ Only covered when prescribed by a physician for the sole purpose of addressing a structure or function of the body (such as physical therapy to address an injury), or the sole purpose of treating a specific disease diagnosed by a physician (such as obesity, diabetes, or heart disease). A letter of medical necessity must be provided to support the claim for benefits.	

Prescription Drug Benefits	Coverage
Annual Deductible	\$75 per person; \$200 family maximum
Out-of-Pocket Maximum⁵ (includes deductible)	\$7,500 per person; \$15,000 per family Combined Medical and Rx Out-of-Pocket Maximum
⁵ The out-of-pocket maximum includes the annual deductible, coinsurance, copays, and medical expenses. Out-of-pocket maximum will increase annually with statutory limit.	
Retail Pharmacy Program	For up to a 30-day supply, Plan covers 100% after you pay:
Generic Medication	\$4 copayment
Diabetes, hypertension, cholesterol, and heart failure medications	\$2 copayment
Formulary Brand-Name Medication	25%; maximum \$55
Diabetes, hypertension, cholesterol, and heart failure medications	25%; maximum \$23.15
Non-Formulary Brand-New Medication	45%; maximum \$90
Diabetes, hypertension, cholesterol, and heart failure medications	45%; maximum \$34.99
Specialty Medication	50%; maximum \$250
Mail Order Program	31-day to 90-day supply, Plan covers 100% after you pay:
Generic Medication	\$10 copayment
Diabetes, hypertension, cholesterol, and heart failure medications	\$4 copayment
Formulary Brand-Name Medication	25%; maximum \$137.50
Diabetes, hypertension, cholesterol, and heart failure medications	25%; maximum \$46.29
Non-Formulary Brand-New Medication	45%; maximum \$225
Diabetes, hypertension, cholesterol, and heart failure medications	45% maximum \$69.98
Specialty Medication	50%; maximum \$250 (up to a 30-day supply)

Dental Benefits	Coverage
Annual Deductible	\$50 per person; \$100 family maximum
Coinsurance	Plan covers:
Preventive, Diagnostic	100%
Basic Care	80%
All Other Care (including Restorative and Orthodontic)	50%
Annual Maximum (only applies to adults aged 19 and over)	\$1,500 per person
Orthodontia Lifetime Maximum	\$2,500 per person

Vision Benefits	Coverage	
	In-Network*	Out-of-Network*
Coinsurance	Not applicable	Not applicable
Calendar Year Maximum	Not applicable	\$300 per person (only applies to adults aged 19 and over)
Exams ⁶	100%	Total exam and materials up to \$300 maximum in a 12-month period
Lenses ⁷	100%	
Frames ⁷	Up to \$150 allowance (\$70 allowance at Costco), or for VSP-featured frames, \$170 allowance	
Elective Contact Lenses	\$200 allowance	
Lens Enhancements		
Polycarbonate, Progressive, Tints/Photo Chromic	Covered in Full	
Anti-Reflective Coating	Covered in Full	
Other Lens Enhancement	\$25.00 Copay	
	Not covered, 40% discount	
⁶ No more than one eye exam is covered during any 12-month consecutive calendar month period.		
⁷ Lenses are only covered when eyeglasses are first acquired or when required by a change in prescription. Only one pair of frames or one pair of lenses will be covered per person during any 12-month consecutive calendar month period.		
*In-network and out-of-network benefits cannot be mixed. For example, you cannot get a vision exam in-network and get frames or contacts out-of-network.		

Hearing	Coverage
Exam	Plan covers up to \$50 in covered expenses, once in a 24-month period; no deductible
Hearing Aids (acquisition and Fitting)	Plan covers 100% up to \$3,000 per person in a 36-month period
AudioNet Provider (Includes hearing aid evaluation test and conformity evaluation)	Copayment if using an AudioNet Provider
○ Essential Level standard digital hearing devices	No copayment, once per person in a 36-month period
○ Mid-Level standard digital hearing devices	No copayment, once per person in a 36-month period
○ Advanced Level standard digital hearing devices	\$110 monaural/\$170 biaural copayment, once per person in a 36-month period
○ Flagship Level standard digital hearing devices	\$380 monaural/\$710 biaural copayment, once per person in a 36-month period.
○ Premium Level standard digital hearing devices	\$730 monaural/\$1,410 biaural copayment, once per person in a 36-month period.
○ Batteries	No copayment for first 48 batteries for the first year only
○ Maintenance/Fittings/Follow-Up Benefits	No copayment for visits within first 6 months; \$20 copayment each following visit for remaining 30 months

Weekly Sickness and Accident Participant Only	Benefit
Non-Occupational	\$340 per week for Actives and Non-Bargained participants, \$105 per week for Production participants ⁷
Occupational	\$105 per week ⁷
⁷ You must apply for Weekly Sickness and Accident benefits within 120 days after the sickness begins or the Injury occurs.	
Benefits Begin	
Non-Occupational Injury	First day
Occupational Illness or Injury	Eighth day
Benefits End	Earlier of recovery or 26 weeks

Death Benefit—Participant Only	Benefit
Benefit	\$15,000 for Actives and Non-Bargained participants \$7,500 for Production and Pre-Medicare Eligible Retirees

Accidental Death and Dismemberment (AD&D) Benefit—Participant Only	Benefit
Benefit	\$15,000 for Actives and Non-Bargained participants \$7,500 for Production participants

Dependent Death Benefit	Benefit
Benefit ⁸	\$5,000 for Actives and Non-Bargained participants \$2,000 for Production participants

⁸ A newborn child becomes covered for Dependent Death Benefits 15 days after the date of birth.

This summary is only highlights of certain features of the Sheet Metal Workers Local No. 20 Welfare and Benefit Plan. Full details are contained in the documents (Summary Plan Description, Plan Document, etc.) that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the Plan Document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan, and to modify contribution rates at any time and from time to time.

IMPORTANT CONTACT INFORMATION

The following chart provides the telephone numbers and/or websites for the various organizations that provide services under the Plan.

If you have a question or need information about:	Contact:	At:
Eligibility	Fund Office	(800) 762-1215 or (317) 549-6005
Claims and Benefits	NEBA	(877) 836-7620
PPO Providers (Blue Card PPO Providers)	Anthem BlueCross BlueShield	(800) 810-BLUE or www.anthem.com
Utilization Management (precertification of certain inpatient/outpatient admissions, services and supplies) and Case Management	Med-Care Management, Inc.	(800) 367-1934
Retail and Mail-Order Prescription Drug Claims	Navitus Health Solutions	(877) 908-6024 or www.navitus.com
PPO Vision Providers	Vision Service Plan (VSP)	(800) 877-7195 or www.vsp.com
PPO Dental Providers	Delta Dental Plan of Indiana	(800) 524-0149 or www.deltadentalin.com
HRA Benefits and Administration	Fund Office	(877) 836-7620
AudioNet Hearing Aid Providers	AudioNet	586) 840-1360 www.audionetamerica.com