# Auto. Mech. Local 701 Welfare Fund: Premier Plus

Coverage Period: Beginning 01/01/2016

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual, Family **Plan Type:** PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.mech701-benefits.org or by calling 1-800-704-6270. You may access the Uniform Glossary at www.dol.gov/ebsa/healthreform.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$250** individual<br>**$500** family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for the covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Chart on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. **$500** per non-Emergency admission to Non-PPO provider. There are no other specific **deductibles.** | You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For major medical: **$2,500** individual**; $5,000** family<br>For prescription drug coverage: **$4,350** individual; **$8700** family<br>Plus Non-PPO<br>**$1,000** individual<br>**$2,000** family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit.** |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of participating providers, visit **www.bcbsil.com** or call **1-800-810-2583.** | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-704-6270 or visit us at www.mech701-benefits.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-704-6270 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount**, for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | PPO Provider | Non- PPO Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% co-insurance | 30% co-insurance | None. |
| | Specialist visit | 20% co-insurance | 30% co-insurance | None. |
| | Other practitioner office visit | 20% co-insurance | 30% co-insurance | Chiropractor limited to 12 visits per person per calendar year. Physician should contact MCM for pre-certification. |
| | Preventive care/screening/immunization | No cost | Not covered | Please refer to the ACA Website for exclusions. http://healthfinder.gov/HealthCareReform |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% co-insurance | 30% co-insurance | Outpatient pre-admission tests covered at no cost with no deductible. Genetic tests that are not required by law are covered if deemed medically necessary, in the judgment of the Plan's Trustees, to treat or manage one or more actual manifested medical symptoms or conditions and if the service or care provided is the most |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | efficient and economical service which can safely be provided. |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | | 30% co-insurance | Outpatient pre-admission tests covered at no cost with no deductible. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.mycatamaranrx.com. | | **Retail** | **Mail** | | |
| | Generic drugs | $6 up to 30-day supply;<br>$11* for each 30-day supply fill after two | $6 for 1-30 day supply;<br>$12 for 31-60 day supply;<br>$15 for 61-90 day supply | Not Covered | * includes a $5 surcharge |
| | Preferred brand drugs (Single Source) | $25 up to 30-day supply;<br>$40 for each 30-day supply fill after two* | $25 for 1-30 day supply;<br>$50 for 31-60 day supply;<br>$65 for 61-90 day supply | Not Covered | * includes a $15 surcharge |
| | Non-preferred brand drugs (Multi-Brand Source) | $40 up to 30-day supply;<br>$55 for each 30-day supply fill after two*, ** | $40 + surcharge 1-30 day supply;<br>$80 + surcharge for 31-60 day supply;<br>$100 + surcharge for 61-90 day supply, ** | Not Covered | *includes a $15 surcharge<br><br>**Applicable surcharge equals difference between multi-source drug and preferred brand drug |
| | Specialty drugs | Specialty drugs are covered at the same level of generic drugs, preferred brand drugs, or non-preferred brand drugs depending on whether the specialty drug falls with any of the other categories. | | Not Covered | None. |
| **If you have outpatient surgery** | Facility fee | 10% co-insurance | | 30% co-insurance | Ambulatory Surgery Centers not covered. |
| | Physician/surgeon fees | 10% co-insurance | | 30% co-insurance | None. |

| | | | | |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | 20% co-insurance | 20% co-insurance (30% if non-emergency) | Non-PPO – subject to $500 deductible for non-emergency admission. |
| | Emergency medical transportation | 20% co-insurance | 20% co-insurance | None. |
| | Urgent care | 20% co-insurance | 30% co-insurance | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% co-insurance | 30% co-insurance | Coverage limited to semi-private room rate. |
| | Physician/surgeon fee | 10% co-insurance | 30% co-insurance | None. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 10% co-insurance | 30% co-insurance | |
| | Mental/Behavioral health inpatient services | 10% co-insurance | 30% co-insurance | |
| | Substance use disorder outpatient services | 10% co-insurance | 30% co-insurance | |
| | Substance use disorder inpatient services | 10% co-insurance | 30% co-insurance | |
| **If you are pregnant** | Prenatal and postnatal care | 20% co-insurance | 30% co-insurance | Preventive care services covered at no cost. |
| | Delivery and all inpatient services | 10% co-insurance | 30% co-insurance | None. |
| **If you need help recovering or have other special health needs** | Home health care | 20% co-insurance | 30% co-insurance | Physician should contact MCM for pre-certification. |
| | Rehabilitation services | 20% co-insurance | 30% co-insurance | Rehabilitative speech therapy to restore normal speech is limited to 30 visits per person per year. Physician should contact MCM for pre-certification. |
| | Habilitation services | 20% co-insurance | 30% co-insurance | Habilitative services to develop a function are limited to 70 visits per person per year (including 30 visits for speech |

| | | | | |
|---|---|---|---|---|
| | | | | therapy). Speech therapy of an idiopathic developmental delay nature, educational or provided by school is not covered. |
| | Skilled nursing care | 20% co-insurance | 30% co-insurance | Physician should contact MCM for pre-certification. |
| | Durable medical equipment | 20% co-insurance | 30% co-insurance | Physician should contact MCM for pre-certification. |
| | Hospice service | 20% co-insurance | 30% co-insurance | Coverage limited to Hospice Care program covered expenses. Physician should contact MCM for pre-certification. |
| **If your child needs dental or eye care** | Eye exam | $10 co-pay | All costs over $35 | Once per calendar year. |
| | Glasses | $20 co-pay | All costs over $40 (single vision), $56 (lined bifocal) or $68 (lined trifocal) | Coverage is limited to up to $150 every 2 years in-network. Coverage is limited to up to $50 every 2 years out-of-network. |
| | Dental check-up | No charge after $25 deductible for routine services | | Basic, Major and Orthodontia services 50% co-insurance. |

**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- **Bariatric Surgery (except in limited circumstances)**
- **Cosmetic Surgery**
- **Genetic Testing (unless approved by the Trustees)**
- **Long Term Care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing**
- **Routine foot care (except for limited orthotics coverage)**
- **Speech therapy for an idiopathic developmental delay nature, educational, or provided by school**
- **Weight loss programs (except as required under the ACA preventive services mandate)**

**Other Covered Services (**This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- **Acupuncture**
- **Chiropractor care (up to 12 visits per person per calendar year. Includes all services & supplies for care of the back, neck, spine and vertebrae).**

**Questions:** Call 1-800-704-6270 or visit us at www.mech701-benefits.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-704-6270 to request a copy.

- **Dental care (Adult)**
- **Hearing aids (up to $600 per person every three years)**
- **Infertility treatment (up to $10,000 per person per lifetime)**
- **Routine eye care (Adult) (once per calendar year)**

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-704-6270. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

**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: Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund, 361 S. Frontage Road, Suite 100, Burr Ridge, IL 60527, 1-800-704-6270; or the 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, IL 60601 (877) 527-9431 http://www.insurance.illinois.gov, or DOI.Director@illinois.gov.

**Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

**Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 708-588-8140.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## Auto. Mech. Local 701 Welfare Fund: Premier Plus

Coverage Period: Beginning 01/01/2016

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual, Family **Plan Type:** PPO

**About these Coverage Examples:**

| Having a baby (normal delivery) | | Managing type 2 diabetes (routine maintenance of a well-controlled condition) | |
|---|---|---|---|
| ▪ **Amount owed to providers:** | **$7,540** | ▪ **Amount owed to providers:** | **$5,400** |

**Questions:** Call 1-800-704-6270 or visit us at www.mech701-benefits.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-704-6270 to request a copy.

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

- **Plan pays** **$6,240**
- **Patient pays** **$1,300**

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care (outpatient) | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests (outpatient) | $500 |
| Prescriptions | $200 |
| Radiology (outpatient) | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $250 |
| Co-pays | $0 |
| Co-insurance | $1,050 |
| Limits or exclusions | $0 |
| **Total** | **$1,300** |

- **Plan pays** **$4,850**
- **Patient pays** **$550**

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | $5,400 |

**Patient pays:**

| | |
|---|---|
| Deductibles | $250 |
| Co-pays | $130 |
| Co-insurance | $170 |
| Limits or exclusions | $0 |
| **Total** | **$550** |

**Questions and answers about the Coverage Examples:**

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

☒**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

☒**No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

√**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

√**Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.