Auto. Mech. Local 701 Welfare Fund: Pre-Medicare Retiree

Coverage Period: Beginning 01/01/2016

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

Coverage for: Individual, Spouse **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?	**$500** individual	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 and **$250** per person prescription drug 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. For prescription drug coverage, **$4,350** individual; **$8,700** family. Plus Non-PPO **$1,000** individual**; $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 non-prescription drug services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	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.**
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 7. See your policy or plan document for additional information about **excluded services.**

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- **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	30% co-insurance	30% co-insurance	None.
	Specialist visit	30% co-insurance	30% co-insurance	None.
	Other practitioner office visit	Chiropractor 30% 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)	30% co-insurance	30% co-insurance	Outpatient pre-admission tests covered at no cost with no deductible. Genetic tests which are not required by law, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics are not covered.
	Imaging (CT/PET scans, MRIs)	30% co-insurance	30% co-insurance	Outpatient pre-admission tests covered at no cost with no deductible

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If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mycatamaranrx.com		**Retail**	**Mail**		
	Generic drugs	You pay 25% $100 max per 30 day supply $100 max + surcharge* for 30 day supply fill after two	You pay 25% $100 max for 1-30 day supply; $200 max for 31-60 day supply; $300 max for 61-90 day supply.	Not covered.	**Retail** *$5 surcharge applies to each re-fill after the 2nd re-fill.
	Preferred brand drugs (Single Source)	You pay 25% $100 max per 30 day supply $100 max + surcharge* for 30 day supply fill after two	You pay 25% $100 max for 1-30 day supply; $200 max for 31-60 day supply; $300 max for 61-90 day supply.	Not covered.	**Retail** *$15 surcharge applies to each re-fill after the 2nd re-fill.
	Non-preferred brand drugs (Multi-Brand Source)	You pay 25% $100 max for 1-30 day supply;	You pay 25% $100 max + surcharge** for 1-30 day supply;	Not covered.	**Retail** *$15 surcharge applies only after 2nd refill at retail. **Mail**

		$200 max for 31-60 day supply; $300 max for 61-90 day supply.	$200 max + surcharge** for 31-60 day supply; $300 max + surcharge** for 61-90 day supply.		**Applicable surcharge equals price difference with generic drugs.
	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	20% co-insurance		30% co-insurance	PPO reference not applicable if Medicare eligible individuals. Ambulatory Surgery Centers not covered.
	Physician/surgeon fees	20% co-insurance		30% co-insurance	None.
If you need immediate medical attention	Emergency room services	30% co-insurance		30% co-insurance	None.
	Emergency medical transportation	30% co-insurance		30% co-insurance	None.
	Urgent care	30% co-insurance		30% co-insurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance		30% co-insurance	Coverage limited to semi-private room rate.
	Physician/surgeon fee	20% co-insurance		30% co-insurance	None.

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	30% co-insurance	None.
	Mental/Behavioral health inpatient services	20% co-insurance	30% co-insurance	None.
	Substance use disorder outpatient services	20% co-insurance	30% co-insurance	None.
	Substance use disorder inpatient services	20% co-insurance	30% co-insurance	None.
If you are pregnant	Prenatal and postnatal care	30% co-insurance	30% co-insurance	Preventive care services covered at no cost.
	Delivery and all inpatient services	20% co-insurance	30% co-insurance	None.
If you need help recovering or have other special health needs	Home health care	30% co-insurance	30% co-insurance	Physician should contact MCM for pre-certification.
	Rehabilitation services	30% co-insurance	30% co-insurance	Rehabilitative speech therapy to restore normal speech is limited to 30 visits per person per year. Therapy to develop the speech function which did not exist is not covered. Physician should contact MCM for pre-certification.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	30% co-insurance	30% co-insurance	Physician should contact MCM for pre-certification.
	Durable medical equipment	30% co-insurance	30% co-insurance	Physician should contact MCM for pre-certification.
	Hospice service	30% 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	Not covered.	Not covered.	None.
	Glasses	Not covered.	Not covered.	None.

	Dental check-up	Not covered	Not covered	None.

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)**
- **Hearing Aids**
- **Long Term Care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing**
- **Routine foot care (except for limited orthotics coverage)**
- **Routine eye care**
- **Weight loss programs (except as required under the ACA preventive services mandate)**
- **Dental care (adult)**

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 and supplies for care of the back, neck, spine and vertebrae).**
- **Infertility treatment (up to $10,000 per person per lifetime).**

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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 <u>does provide</u> minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

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

About these Coverage Examples:

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.

Having a baby (normal delivery)	
▪ **Amount owed to providers:**	**$7,540**
▪ **Plan pays**	**$5,000**
▪ **Patient pays**	**$2,540**
Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	$500
Co-pays	$0
Co-insurance	$2,040
Limits or exclusions	$0
Total	**$2,540**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
▪ **Amount owed to providers:**	**$5,400**
▪ **Plan pays**	**$4,320**
▪ **Patient pays**	**$1,080**
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	$500
Co-pays	$400
Co-insurance	$180
Limits or exclusions	$0
Total	**$1,080**

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.