Auto. Mech. Local 701 Welfare Fund: Classic Bargained

Coverage Period: Beginning 01/01/2014

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?	**$1,000** individual **$3,000** 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 Hospital and $400 deductible for ER services (but waived if admitted). 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. **$6,000** individual **$12,700** family Plus Non-PPO **$2,000** individual **$11,300** 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, 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?	Per person 2013 – $2,000,000 2014 – No limit	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of 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 4. 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 PPO Provider	Your cost if you use a Non- PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	35% co-insurance	None.
	Specialist visit	20% co-insurance	35% co-insurance	None.
	Other practitioner office visit	20% co-insurance	35% 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	None.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	35% 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)	20% co-insurance	35% co-insurance	Outpatient pre-admission tests covered at no cost with no deductible
If you need drugs to treat your illness or condition More information about	Generic drugs	25% **Retail** ($5min/$20max) **Mail** ($10min/$40max) for	*25% ($5min/$20max) + surcharge*	* $5 surcharge applies only after 2nd refill at retail.

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prescription drug coverage is available at www.mycatamaranrx.com		a 31-60 day supply; ($15min/$60max) for a 61-90 day supply.		
	Preferred brand drugs (Single Source)	30% **Retail** ($25min/$100 max) **Mail** ($50min/$200 max) for a 31-60 day supply; ($75min/$300 max) for a 61-90 day supply.	30% **Retail** ($25min/$100max) + surcharge*	* $15 surcharge applies only after 2nd refill at retail.
	Non-preferred brand drugs (Multi-Brand Source)	35% **Retail** ($31.25min/$125max) **Mail** ($62.50min/$250max) + surcharge for a 31-60 day supply; ($93.75/$375max) + surcharge for a 61-90 day supply.	35% **Retail** ($31.25min/$125max) + surcharge	**Retail** * $15 surcharge applies after 2nd refill at retail. **Mail** Applicable surcharge equals difference between multi-brand source drug and preferred brand 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	Not Covered.	None.
	Physician/surgeon fees	20% co-insurance	35% co-insurance	None.

If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance (35% if non-emergency)	If non-emergency, deductible applies.
	Emergency medical transportation	20% co-insurance	20% co-insurance	None.
	Urgent care	20% co-insurance	35% co-insurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	35% co-insurance	Coverage limited to semi-private room rate.
	Physician/surgeon fee	20% co-insurance	35% co-insurance	None.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% co-insurance	50% co-insurance	30 visits per person maximum annual
	Mental/Behavioral health inpatient services	10% co-insurance	50% co-insurance	15 days per pers./15 physician visits annual
	Substance use disorder outpatient services	20% co-insurance of first $5,000; 50% thereafter	50% co-insurance	PPO – 50% after first $5,000
	Substance use disorder inpatient services	10% co-insurance	35% co-insurance	Non-PPO subject to $500 deductible for non-emergency admission. Limited to one 21-day stay per person per lifetime.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	35% co-insurance	Preventive care services covered at no cost
	Delivery and all inpatient services	20% co-insurance	35% co-insurance	None.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	35% co-insurance	Physician should contact MCM for pre-certification.
	Rehabilitation services	20% co-insurance	35% co-insurance	Rehabilitative speech therapy to restore normal speech is limited to 30 visits per person per year. Speech therapy of an idiopathic developmental delay nature, educational or provided by school is not covered. Rehabilitative physical therapy is limited to 20 visits per year. Physician should contact MCM for pre-certification.
	Habilitation services	20% co-insurance	35% co-insurance	Habilitative services to develop a function are limited to 70 visits per

				person per year (including 30 visits for speech therapy).
	Skilled nursing care	20% co-insurance	35% co-insurance	Physician should contact MCM for pre-certification.
	Durable medical equipment	20% co-insurance	35% co-insurance	Physician should contact MCM for pre-certification.
	Hospice service	20% co-insurance	35% 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	No cost No deductible	100% of expenses over $25	Once per calendar year.
	Glasses	100% of expenses over $75	Materials not covered	PPO services are limited to every 2 years per person. Additionally, covered individuals are eligible for a 20% discount on materials
	Dental check-up	No charge after $25 deductible for routine services. 50% co-insurance for basic services.	Not Covered	Major services and orthodontia are not covered.

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**
- **Cosmetic Surgery**
- **Genetic Testing**
- **Long Term Care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing**
- **Routine foot care**
- **Speech therapy for an idiopathic developmental delay nature, educational, or provided by school**
- **Weight loss programs**

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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 (by MD, OD, DC or DN only)** • **Chiropractor care (up to 12 visits per person per calendar year – includes all services and supplies provided by a licensed chiropractor).** • **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, 500 West Plainfield Road, Countryside, IL 60525, 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 or policy does provide 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 does meet the minimum value standard for the benefits it provides**.

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

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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**	**$5,280**
▪ **Patient pays**	**$2,260**
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	$1,000
Co-pays	$0
Co-insurance	$1,260
Limits or exclusions	$0
Total	**$2,260**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
▪ **Amount owed to providers:**	**$5,400**
▪ **Plan pays**	**$4,250**
▪ **Patient pays**	**$1,150**
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	$1,000
Co-pays	$130
Co-insurance	$20
Limits or exclusions	$0
Total	**$1,150**

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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 he same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan providers.

Are there other costs I should consider when comparing plans?

√**Yes.** An important costs 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.