Automobile Mechanics' Local #701 Welfare Fund
Pre-Medicare Retirees Plan- Enhanced Option Schedule of Benefits (July 1, 2025 Edition)

Comprehensive Medical Benefit (Pre-Medicare Retirees and their Dependents)	
Deductibles	
• Calendar Year Deductible	$250 per person; $500 per family
• Non-PPO Hospital Deductible	$500 per person for each non-Emergency admission to a Non-PPO Hospital (in addition to the calendar year deductible)
Calendar Year Out-of-Pocket Maximums[1]	
• PPO – Major Medical – Prescription Drug[2]	 $2,500 per person; $5,000 per family $6,700 per person; $13,400 per family
• Additional Non-PPO Maximum	$1,000 per person; $2,000 per family
Calendar Year Plan Maximums	
• Chiropractic/Spinal Care	24 visits per person
• Nutritional Counseling[3]	12 visits per person
• Rehabilitative Speech Therapy (to restore normal speech)	30 visits per person
• Rehabilitative Physical Therapy	20 visits per person[4]
• Habilitative Outpatient Physical and Speech Therapy	30 visits for Speech Therapy or a combined 70 visits for Speech and Physical Therapy
Special Benefit Maximums	
• Hospital Daily Room and Board	Single room rate
• Non-PPO Hospital Intensive Care	Full Reasonable and Customary Rate
• Hearing Aid Program	$2,500 per person every three years
• Infertility Treatment[5]	$10,000 per person per lifetime

Comprehensive Medical Benefit (Pre-Medicare Retirees and their Dependents)		
Type of Service	**PPO Provider**	**Non-PPO Provider**
• Outpatient Pre-Admission Tests	Plan pays 100%; no deductible	Plan pays 100%; no deductible
• Hospital Inpatient and Outpatient Surgeries & Hospital Inpatient Services	Plan pays 90% (including surgeries during office visits)	Plan pays 70%
• Emergency Room or Emergency Services for an Emergency Medical Condition	Plan pays 80%	Plan pays 80% of the lesser of the amount billed or the Qualifying Payment Amount ("QPA") Plan pays 70% if not an Emergency
• Ground Ambulance	Plan pays 80%	Plan pays 80%
• Air Ambulance	Plan pays 80%	Plan pays 80% of the lesser of the amount billed or the QPA
• Preventive Services	Plan pays 100%; no deductible	Not covered
• Non-Hospital Services (e.g., Office Visits, Lab Tests)	Plan pays 80%	Plan pays 70%
• Chiropractic/Spinal Care[6]	Plan pays 80% for up to 24 visits per person per calendar year	Plan pays 70% for up to 24 visits per person per calendar year
• Substance Abuse Treatment[7] – Inpatient – Outpatient	 Plan pays 90% Plan pays 90%	 Plan pays 70% Plan pays 70%
• Mental Health Treatment – Inpatient – Outpatient	 Plan pays 90% Plan pays 90%	 Plan pays 70% Plan pays 70%
• Hearing Aid Program	Plan pays 100% up to $2,500 per person every three years	Plan pays 100% up to $2,500 per person every three years
• Ambulatory Surgical Center	Plan pays 90%	Not covered
• Other Covered Medical Expenses	Plan pays 80%	Plan pays 70%
• Overweight or Obesity Condition-Related Expenses	Plan pays 50%[8]	Not covered

[1] Excludes amounts paid for non-covered expenses.

[2] The prescription drug calendar year out-of-pocket maximum will be adjusted annually so that the combined out-of-pocket maximums for prescription drugs and major medical equal the maximum permitted under the Affordable Care Act ("ACA").

[3] Must be referred by a licensed Physician prior to being covered. Only visits with a Physician, licensed nutritionist, or registered dietician provider will be covered.

[4] Rehabilitative Physical Therapy will be approved in excess of the Calendar Year Plan Maximum if approved in advance by pre-certification, case management, and utilization review. To ensure you receive the maximum benefits available under the Plan, you should ask your Physician to contact Conifer Health prior to receiving treatment.

[5] Expenses to determine Infertility are not included under the lifetime maximum.

[6] Chiropractic/spinal care includes all services and supplies for care of the back, neck, spine, and vertebrae.

[7] Inpatient treatment is covered if it is provided by a Hospital or approved Residential Treatment Facility.

[8] Expenses for treatment rendered in connection with overweight or obesity conditions are covered in limited circumstances. Please see the full Summary Plan Description for further information about the circumstances in which such expenses are covered under the Plan.

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• Telemedicine Services	Plan pays 100% with no deductible for specifically contracted services with Teladoc; Plan pays 80% for all other network providers (excludes physical therapy)	Plan pays 70% (excludes physical therapy)
• Imaging Procedures (CT/PET scans, MRIs)	Plan pays 100% with no deductible if the Plan's designated imaging provider is used; Plan pays 80% for non-contracted providers	Plan pays 70%
Prescription Drug Benefits (Pre-Medicare Retirees and Dependents)		
Calendar Year Out-of-Pocket Maximum for Prescription Drugs[9]	$6,700 per person; $13,400 per family	
Network Retail Pharmacies	**For up to a 30-day supply, you pay the lesser of the actual drug cost or:**	
• Generic Medication	$6 copayment	
• Preferred Brand Drug	$25 copayment	
• Non-Preferred Brand Drug	$40 copayment	
Mail Order Service or Network Retail Pharmacies	**For up to a 90-day supply, you pay the lesser of the actual drug cost or:**	
• Generic Medication	$15 copayment	
• Preferred Brand Drug	$65 copayment	
• Non-Preferred Brand Drug	$100 copayment	
• Specialty Drugs	100% co-insurance. If co-insurance assistance is unavailable for a drug, the co-insurance defaults to the tiered structure shown above	
• Immunizations administered through the Fund's pharmacy benefits manager	Plan pays 100% (please see SPD for a list of specific covered immunizations)	
• Diabetic Testing Supplies and Syringes	Plan pays 100%	

Dental Benefits (Pre-Medicare Retirees and Dependents)	
Calendar Year Maximum (not applicable to preventive oral care for eligible Dependent children under age 19)	$3,000 per person
Lifetime Orthodontia Maximum	$4,000 per person
Calendar Year Deductible	
• Routine Dental Services	$25 per person
• All Other Covered Dental Services	None
Copayment Percentages	
• Routine Dental Services	Plan pays 100% after deductible
• Basic Dental Services, Major Dental Services & Orthodontia	Plan pays 80%

Vision Benefits (Pre-Medicare Retirees and Dependents)		
	Network Provider	**Non-Network Provider**
Complete Eye Exam (One per calendar year)	$10 copayment	Plan pays up to $35 per person
Single Vision Lenses	$20 copayment every calendar year for lenses and/or frame	Plan pays up to $40 per person every year
Anti-Reflective Coating Premium/Custom Progressive Lenses Scratch Resistant Coating	$30 copayment $50 copayment Up to 30%-35% Savings	Not covered
Frames	$20 copayment for lenses and/or frame. Plan pays up to $200 every calendar year	Plan pays up to $50 per person every calendar year
Contact Lenses	In place of frames and lenses, Plan pays up to $200 every calendar year for contacts after copayment (up to $60) for contact lens exam	Plan pays up to $90 per person every calendar year

[9] The prescription drug calendar year out-of-pocket maximum will be adjusted annually so that the combined out-of-pocket maximums for prescription drugs and major medical equal the maximum permitted under the Affordable Care Act ("ACA").

Lasik Surgery	Plan pays up to $250 per eye for $500 total allowance after 15% discount if surgery performed at network provider	Not covered