Auto. Mech. Local 701 Welfare Fund: Premier Plus

Coverage Period: Beginning 01/01/2018

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

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.mech701-benefits.org or call 1-800-704-6270. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-704-6270 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual **$500** family	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Preventive care**, outpatient pre-admission tests, and certain diabetic supplies under the Plan's **prescription drug** benefit are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$500** per non-Emergency admission to **out-of-network providers**. 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.
What is the out-of-pocket limit for this plan?	For major medical **network providers**: **$2,500** individual**; $5,000** family; For **prescription drug coverage**: **$4,850** individual; **$9,700** family; For **out-of-network providers**, an additional **$1,000** individual; **$2,000** family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own out-of-pocket limits until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billing** charges, health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Will you pay less if you use a network provider?	Yes. See **www.bcbsil.com** or call **1-800-810-2583** for a list of **network providers.**	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider's charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't **preventive**. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for.
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**.
	Imaging (CT/PET scans, MRIs)	20% **co-insurance** (0% **co-insurance** and no **deductible** if you use a **provider** contracted with the **Plan**'s designated imaging provider network)	30% **co-insurance**	Outpatient pre-admission tests covered at no cost with no **deductible**. If you use a provider contracted with the **Plan**'s designated imaging provider network (One Call Care Management), then imaging services are covered at no cost to you.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available		**Retail**	**Mail or Walgreens Pharmacies**	
	Generic drugs	You pay the lesser of the actual drug cost or: $6 for up to 30-day supply (limited to two fills)	You pay the lesser of the actual drug cost or: $15 for 90-day supply	Not Covered	After two fills at retail (other than Walgreens), you will be charged the full drug cost, subject to network discounts, for maintenance medications.

Excluded Services & Other Covered Services:

at www.express-scripts.com.	Preferred brand drugs	You pay the lesser of the actual drug cost or: $25 for up to 30-day supply (limited to two fills)	You pay the lesser of the actual drug cost or: $65 for 90-day supply	Not Covered	After two fills at retail (other than Walgreens), you will be charged the full drug cost, subject to network discounts, for maintenance medications.
	Non-preferred brand drugs	You pay the lesser of the actual drug cost or: $40 for each 30-day supply (limited to two fills)	You pay the lesser of the actual drug cost or: $100 for 90-day supply	Not Covered	After two fills at retail (other than Walgreens), you will be charged the full drug cost, subject to network discounts, for maintenance medications.
	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 within any of the other categories.		Not Covered	Same as the applicable level of generic drugs, preferred brand drugs, or non-preferred brand drugs.
If you have outpatient surgery	Facility fee	10% **co-insurance**		30% **co-insurance**	**Out-of-network** 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)	
	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**	**Preauthorization** is required. Coverage limited to single private room rate. Coverage at **out-of-network** Hospital Intensive Care limited to three times semi-private room rate (or three times single room rate if semi-private unavailable). **Out-of-network providers** subject to $500 **deductible** for non-emergency admission.

	Physician/surgeon fee	10% **co-insurance**	30% **co-insurance**	None.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	10% **co-insurance**	30% **co-insurance**	None.
	Inpatient services	10% **co-insurance**	30% **co-insurance**	**Preauthorization** is required. Inpatient substance abuse services are covered if provided by a Hospital or approved Residential Treatment Facility.
If you are pregnant	Office visits	20% **co-insurance**	30% **co-insurance**	**Preventive care** services covered at no cost at PPO providers. Expenses for a dependent child's pregnancy not covered, except as required under applicable law.
	Childbirth/delivery professional services	10% **co-insurance**	30% **co-insurance**	
	Childbirth/delivery facility services	10% **co-insurance**	30% **co-insurance**	
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 **preauthorization**.
	Rehabilitation services	20% **co-insurance**	30% **co-insurance**	30 rehabilitative speech therapy visits/year per person; 20 rehabilitative physical therapy visits/year per person. Physician should contact MCM for **preauthorization**.
	Habilitation services	20% **co-insurance**	30% **co-insurance**	Habilitative services to develop a function are limited to 70 visits/year per person (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 **preauthorization**.
	Durable medical equipment	20% **co-insurance**	30% **co-insurance**	Physician should contact MCM for **preauthorization**.
	Hospice service	20% **co-insurance**	30% **co-insurance**	Coverage limited to Hospice Care program covered expenses. Physician should contact MCM for **preauthorization**.
If your child needs dental or eye care	Children's eye exam	$10 **co-pay**	All costs over $35	Coverage limited to one exam per calendar year.

	Children's glasses	$20 **co-pay**	All costs over $40 (single vision), $56 (lined bifocal) or $68 (lined trifocal)	Coverage limited to $150 every 2 years at **network providers** or $50 every 2 years at **out-of-network providers**.
	Children's dental check-up	No charge after $25 **deductible** for routine services	See p. 51 of SPD for coverage details	Basic, Major and Orthodontia services covered at 50% **co-insurance**; $1,000 calendar year maximum for dental benefits (except for preventive oral care for children under 19); $2,000 per person lifetime orthodontia maximum.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any for other excluded services.)

- Cosmetic Surgery
- Genetic Testing (unless approved by the Trustees)
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Pregnancy coverage for dependent children
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery (subject to certain conditions)
- Chiropractor care (up to 12 visits per person per calendar year; includes services for care of the back, neck, spine and vertebrae)
- 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: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol/gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 1-800-704-6270.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,340
What isn't covered	
Limits or exclusions	$210
The total Peg would pay is	**$1,800**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$710
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	**$1,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$350
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.