



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, go to www.mech701-benefits.org or call 1-800-704-6270. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [co-insurance](#), [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 <u>deductible</u>?	\$1,000 individual \$3,000 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 <u>deductible</u>?	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 co-insurance 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 <u>deductibles</u> for specific services?	Yes. \$500 per non-Emergency admission to out-of-network providers and \$400 deductible for emergency services (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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For major medical network providers : \$5,000 individual; \$10,000 family; For prescription drug coverage : \$2,900 individual; \$5,800 family; For out-of-network providers , an additional \$2,000 individual; \$11,300 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 <u>out-of-pocket limit</u>?	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 <u>network provider</u>?	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 <u>referral</u> to see a specialist?	No.	You can see the specialist you choose without a referral .

Automobile Mechanics' Local #701 Welfare Fund: Classic Bargained Plan Coverage Period: Beginning 01/01/2019

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

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



All **copayment** and **co-insurance** 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 <u>provider's</u> 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.
	Preventive care/ screening/ immunization	No charge; deductible does not apply	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	35% 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)	35% 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 at www.express-scripts.com .		Retail	Mail or Walgreens Pharmacies	
	Generic drugs	You pay 25% (\$5 min/\$20 max) for up to a 30-day supply (limited to two fills)	You pay 25% (\$15 min/\$60 max) for up to a 90-day supply	Not covered
	Preferred brand drugs	You pay 30% (\$25 min/\$100 max) for up to a 30-day supply (limited to two fills)	You pay 30% (\$75 min/\$300 max) for up to a 90-day supply	Not covered

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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)		
	Non-preferred brand drugs	You pay 35% (\$31.25 min/\$125 max) for up to a 30-day supply (limited to two fills)	You pay 35% (\$93.75 min/\$375 max) for up to a 90-day supply	Not covered	After two fills at retail (other than 90 day fills at Walgreens), you will be charged the full drug cost, subject to network discounts, for maintenance medications.
	Specialty drugs	30% co-insurance . If co-insurance assistance is unavailable for a drug, its co-insurance defaults to the tiered structure shown above.		Not Covered	The Fund's contracted specialty drug case manager will work with drug manufacturers so that the cost to you does not exceed the tiered structure shown herein.
If you have outpatient surgery	Facility fee	20% co-insurance		35% co-insurance	Out-of-network ambulatory surgery centers not covered.
	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 not admitted, \$400 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	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	20% co-insurance		35% co-insurance	None.
If you have mental health, behavioral	Outpatient services	20% co-insurance		30% co-insurance	None.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
health, or substance abuse needs	Inpatient services	10% <u>co-insurance</u>	30% <u>co-insurance</u>	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% <u>co-insurance</u>	35% <u>co-insurance</u>	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	20% <u>co-insurance</u>	35% <u>co-insurance</u>	
	Childbirth/delivery facility services	20% <u>co-insurance</u>	35% <u>co-insurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>co-insurance</u>	35% <u>co-insurance</u>	Physician should contact MCM for preauthorization .
	<u>Rehabilitation services</u>	20% <u>co-insurance</u>	35% <u>co-insurance</u>	30 rehabilitative speech therapy visits/year per person; 20 rehabilitative physical therapy visits/year per person. Physician should contact MCM for preauthorization .
	<u>Habilitation services</u>	20% <u>co-insurance</u>	35% <u>co-insurance</u>	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.
	<u>Skilled nursing care</u>	20% <u>co-insurance</u>	35% <u>co-insurance</u>	Physician should contact MCM for preauthorization .
	<u>Durable medical equipment</u>	20% <u>co-insurance</u>	35% <u>co-insurance</u>	Physician should contact MCM for preauthorization .
	<u>Hospice service</u>	20% <u>co-insurance</u>	35% <u>co-insurance</u>	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	No charge; <u>deductible</u> does not apply	All costs over \$25 per person	Coverage limited to one exam per calendar year.

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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)	
	Children's glasses	All costs over \$100 per person every 2 years	Not covered	Coverage limited to \$100 every 2 years.
	Children's dental check-up	No charge after \$25 deductible for routine services	Fees and costs above what is allowed and agreed as Reasonable and Customary	Basic dental services covered at 50% co-insurance . Major dental services and orthodontia not covered. \$1,000 calendar year maximum for dental benefits (except for preventive oral care for children under 19)

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
<ul style="list-style-type: none"> • 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.)
<ul style="list-style-type: none"> • 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) (except major dental services and orthodontia) • 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 [co-insurance](#)) 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](#) \$1,000
- [Specialist co-insurance](#) 20%
- [Hospital \(facility\) co-insurance](#) 20%
- [Other co-insurance](#) 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Co-insurance	\$2,280
<i>What isn't covered</i>	
Limits or exclusions	\$210
The total Peg would pay is	\$3,490

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist co-insurance](#) 20%
- [Hospital \(facility\) co-insurance](#) 20%
- [Other co-insurance](#) 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Co-insurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$40
The total Joe would pay is	\$2,340

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist co-insurance](#) 20%
- [Hospital \(facility\) co-insurance](#) 20%
- [Other co-insurance](#) 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Co-insurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,400

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.