Automobile Mechanics' Local #701 Welfare Fund
Pre-Medicare Retirees Plan- Enhanced Option Schedule of Benefits (2021 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 $6,050 per person; $12,100 per family
• Additional Non-PPO Maximum	$1,000 per person; $2,000 per family
Calendar Year Plan Maximums	
• Chiropractic/Spinal Care	12 visits per person
• Rehabilitative Speech Therapy (to restore normal speech)	30 visits per person
• Rehabilitative Physical Therapy	20 visits per person[3]
• Habilitative outpatient Physical and Speech Therapy	30 visits for Speech Therapy and 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[4]	$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	Plan pays 80%	Plan pays 80% (70% if not Emergency)
• 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[5]	Plan pays 80% for up to 12 visits per person per calendar year	Plan pays 70% for up to 12 visits per person per calendar year
• Substance Abuse Treatment[6] – 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%[7]	Not covered
• Telemedicine Services	Plan pays 100% for specifically contracted services with Plan's selected vendor; no deductible	Not covered
• Imaging Procedures	Plan pays 100% with no	Plan pays 70%

[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] 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 MCM prior to receiving treatment.

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

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

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

[7] 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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(CT/PET scans, MRIs)	deductible if the Plan's designated imaging provider is used; Plan pays 80% for non-contracted providers	
Prescription Drug Benefits (Pre-Medicare Retirees and Dependents)[8]		
Calendar Year Out-of-Pocket Maximum for Prescription Drugs[9]	$6,050 per person; $12,100 per family	
Participating Retail Pharmacy Program	**For up to a 30-day supply, you pay the lesser of actual drug cost or:**	**For each 30-day supply fill at Retail after two, you pay:**
• Generic Medication	$6 copayment	Not covered
• Preferred Brand Drug	$25 copayment	Not covered
• Non-Preferred Brand Drug	$40 copayment	Not covered
Mail Order Service or Walgreens Retail Pharmacies (required after two fills)	**For up to a 90-day supply, you pay:**	
• Generic Medication	$15 (or actual drug cost, if less) at Walgreens; $15 through mail order	
• Preferred Brand Drug	$65 (or actual drug cost, if less) at Walgreens; $65 through mail order	
• Non-Preferred Brand Drug	$100 (or actual drug cost, if less) at Walgreens; $100 through mail order	
• Specialty Drugs	100% co-insurance. If co-insurance assistance is unavailable for a drug, its co-insurance defaults to the tiered structure shown above	
• Immunizations administered through the Fund's pharmacy benefits manager	Plan pays 100% (please see SMM 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)	$2,000 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 50%	
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
Scratch Resistant Coating, Anti-Reflective Coating, Progressives	25%- 30% savings	N/A
Frames	$20 copayment for lenses and/or frame. Plan pays up to $175 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 $175 every calendar year for contacts and contact lens exam	Plan pays up to $90 per person every calendar year
Lasik Surgery	Plan pays up to $250 per eye for $500 total allowance after 15% discount if surgery performed at network provider	Plan pays up to $250 per eye for $500 total allowance

[8] After two fills at retail (other than 90-day fills at Walgreens Retail Pharmacies), you will not be able to have your maintenance medications filled at any other retail pharmacy.

[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").