Premier Plus Plan Schedule of Benefits (2017 Edition)

Comprehensive Medical Benefit (Active Employees and their Dependents)	
Deductibles	
• Calendar Year Deductible	$250 per person; $500 per family[1]
• 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[2]	
• PPO – Major Medical – Prescription Drug[3]	 $2,500 per person; $5,000 per family $4,650 per person; $9,300 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[4]
• 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	Three times semi-private room rate (three times single room rate if semi-private rooms unavailable)
• Hearing Aid Program	$600 per person every three years
• Infertility Treatment[5]	$10,000 per person per lifetime

Comprehensive Medical Benefit (Active Employees 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[6]	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[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 $600 per person every three years	Plan pays 100% up to $600 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
• Telemedicine Services	Plan pays 100% for specifically contracted services with Plan's selected vendor; no deductible	Not covered

Prescription Drug Benefits (Active Employees and Dependents)

1 If you are a newly organized Employee, you may be able to use amounts paid toward annual deductibles under your prior health coverage toward your calendar year deductible under the Plan if your Employer previously made arrangements with the Fund and if you submit substantiation records of such expenses to the Fund Office within 90 days of the date you are first eligible for Active Employee Benefits under the Plan.

2 Excludes amounts paid for non-covered expenses.

3 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).

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 MCM 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 and treatment is based on completion of a course of treatment and the discharge is certified by a Physician.

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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Calendar Year Out-of-Pocket Maximum for Prescription Drugs[9]	$4,650 per person; $9,300 per family		
Participating Retail Pharmacy Program	**For up to a 30-day supply, you pay:**	**For each 30-day supply fill at Retail after two, you pay:**	
• Generic Medication	$6 copayment	$6 copayment + $5 surcharge	
• Single Source Brand Drug	$25 copayment	$25 copayment + $15 surcharge	
• Multi-Source Brand Drug	$40 copayment	$40 copayment + $15 surcharge	
Mail Order Service (preferred after two fills)	**For 1-30 day supply, you pay:**	**For 31-60 day supply, you pay:**	**For 61-90 day supply, you pay:**
• Generic Medication	$6	$12	$15
• Single Source Brand Drug	$25	$50	$65
• Multi-Source Brand Drug	$40 + surcharge	$80 + surcharge	$100 + surcharge
Dental Benefits (Active Employees and Dependents)			
Calendar Year Maximum (not applicable to preventive oral care for eligible Dependent children under age 19)	$1,000 per person		
Lifetime Orthodontia Maximum	$2,000 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 (Active Employees 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 two years for lenses and/or frame	Plan pays up to $40 per person every two years	
Scratch Resistant Coating, Anti-Reflective Coating, Progressives	25%- 30% savings	N/A	
Frames	$20 copayment for lenses and/or frame. Plan pays up to $150 every two calendar years	Plan pays up to $50 per person every two calendar years	
Contact Lenses	In place of frames and lenses, Plan pays up to $150 every two years for contacts and contact lens exam	Plan pays up to $90 per person every two calendar years	
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	

Weekly Disability Benefits (Active Employees Only)[10]	
Benefit Amount	$300 per week for up to 26 weeks
Benefits Begin	
• For immediate disability due to an accidental and non-occupational Injury	First day
• For disabilities due to non-occupational Illness	Eighth day
Death Benefit (Active Employees and Totally Disabled Former Active Employees Only)	
Amount	$20,000
Accidental Death & Dismemberment Benefit (Active Employees Only)	
• Death • Both Hands • Both Feet • One Hand and One Foot • Entire Sight of Both Eyes • One Hand and Entire Sight of One Eye • One Foot and Entire Sight of One Eye	$20,000
• One Hand • One Foot • Entire Sight of One Eye	$10,000

[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).

[10] No benefits shall be paid for any period during which you are receiving a pension or disability pension from the Automobile Mechanics' Local No. 701 Union and Industry Pension Plan.