

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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, go to www.mech701-benefits.org or call 708-482-0110. 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 708-482-0110 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$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 <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 person for each non-Emergency admission to a Non-PPO Hospital . 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 : \$2,500 individual; \$5,000 family; For prescription drug coverage : \$8,100 individual; \$16,200 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 <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 .



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 provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>co-insurance</u>	30% <u>co-insurance</u>	None.	
	<u>Specialist</u> visit	20% <u>co-insurance</u>	30% <u>co-insurance</u>	None.	
	<u>Preventive care/ screening/ immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>co-insurance</u>	30% <u>co-insurance</u>	Outpatient pre-admission tests covered at no cost with no <u>deductible</u> . Preauthorization is required for genetic tests that are not required by law.	
	Imaging (CT/PET scans, MRIs)	20% <u>co-insurance</u> (0% <u>co-insurance</u> and no <u>deductible</u> if you use a <u>provider</u> contracted with the <u>Plan</u> 's designated imaging provider network)	30% <u>co-insurance</u>	Outpatient pre-admission tests covered at no cost with no <u>deductible</u> . If you use a provider contracted with the <u>Plan</u> 's designated imaging provider network (Absolute Solutions), then imaging services are covered at no cost to you.	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com		Network Pharmacies - 30 You pay the lesser of the actual drug cost or:	Mail or Network Pharmacies - 90 You pay the lesser of the actual drug cost or:		
	Generic drugs	\$6 for up to a 30-day supply	\$15 for a 90-day supply	Not Covered	None.
	Preferred brand drugs	\$25 for up to a 30-day supply	\$65 for a 90-day supply	Not Covered	If you request a Brand Name Medication and a Generic Medication is available, you

 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)	
				will be required to pay the difference between the cost of the Generic Medication and the Brand Name Medication.
	Non-preferred brand drugs	\$40 for up to a 30-day supply	\$100 for a 90-day supply	If you request a Brand Name Medication and a Generic Medication is available, you will be required to pay the difference between the cost of the Generic Medication and the Brand Name Medication.
	Specialty drugs	Non-Essential Health Benefits ("NEHB") Specialty Medications are subject to 30% <u>co-insurance</u> However, when enrolled with SaveOnSP you will be paying \$0 for NEHB Specialty Medications For Non-NEHB Specialty Medications, the <u>co-insurance</u> defaults to the tiered structure shown above		Contact the Fund Office for a list of specialty drugs included in the copay assistance benefit drug list through SaveOnSP.
If you have outpatient surgery	Facility fee	10% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Out-of-network</u> ambulatory surgery centers not covered.
	Physician/surgeon fees	10% <u>co-insurance</u>	30% <u>co-insurance</u>	None.
If you need immediate medical attention	<u>Emergency room services</u>	20% <u>co-insurance</u>	20% <u>co-insurance</u> (30% if non-emergency)	None.
	<u>Emergency medical transportation</u>	20% <u>co-insurance</u>	20% <u>co-insurance</u>	None.
	<u>Urgent care</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	None.

Automobile Mechanics' Local #701 Welfare Fund: Premier Plus Plan Coverage Period: 01/01/2026-12/31/2026
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **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 have a hospital stay	Facility fee (e.g., hospital room)	10% <u>co-insurance</u>	30% <u>co-insurance</u>	Preauthorization is required. Coverage limited to single private room rate. Coverage at out-of-network Hospital Intensive Care limited to Full Reasonable and Customary Rate. Non-PPO Hospitals are subject to a \$500 <u>deductible</u> for non-emergency admission.
	Physician/surgeon fee	10% <u>co-insurance</u>	30% <u>co-insurance</u>	None.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	10% <u>co-insurance</u>	30% <u>co-insurance</u>	None.
	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>	30% <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	10% <u>co-insurance</u>	30% <u>co-insurance</u>	
	Childbirth/delivery facility services	10% <u>co-insurance</u>	30% <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>	30% <u>co-insurance</u>	Physician should contact Conifer for preauthorization .
	<u>Rehabilitation services</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	30 rehabilitative speech therapy visits/year per person, 30 rehabilitative physical therapy visits/year per person, and 30 rehabilitative occupational therapy visits/year per person. A Physician's order

 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)	
				and preauthorization from Conifer is required prior to the first visit.
	<u>Habilitation services</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	No visit limit for habilitative speech therapy, habilitative physical therapy, and habilitative occupational therapy. A Physician's order and preauthorization from Conifer is required prior to the first visit. 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>	30% <u>co-insurance</u>	Physician should contact Conifer for preauthorization .
	<u>Durable medical equipment</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	Physician should contact Conifer for preauthorization .
	<u>Hospice service</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	Coverage limited to Hospice Care program covered expenses. Physician should contact Conifer for preauthorization .
If your child needs dental or eye care	Children's eye exam	\$10 <u>co-pay</u>	All costs over \$35	Coverage limited to one exam per calendar year.
	Children's glasses	\$20 <u>co-pay</u>	All costs over \$40 (single vision), \$56 (lined bifocal), or \$68 (lined trifocal)	Coverage limited to \$200 every calendar year at <u>network providers</u> or \$50 every year at <u>out-of-network providers</u> .
	Children's dental check-up	No charge after \$25 <u>deductible</u> for routine services	Fees and costs above what is allowed and agreed as	Basic, Major and Orthodontia services covered at 80% <u>co-insurance</u> ; \$3,000 calendar year maximum for dental benefits (except for preventive oral care for children

 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)	
			Reasonable and Customary	under 19); \$4,000 per person lifetime orthodontia maximum.

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.)

- Cosmetic Surgery
- Gene and Cellular Therapy Treatments and Gene and Cellular Therapy Prescription Drugs
- 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)
- Chiropractic care (up to 24 visits per person per calendar year; includes services for care of the back, neck, spine, and vertebrae)
- Dental care (Adult)
- Hearing aids (up to \$2,500 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.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 708-482-0110.

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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual, Family

Plan Type: PPO

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	\$250
■ Specialist co-insurance	20%
■ Hospital (facility) co-insurance	10%
■ 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$10
Co-insurance	\$1,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,720

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 co-insurance	20%
■ Hospital (facility) co-insurance	10%
■ 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$100
Co-insurance	\$400
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$770

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$250
■ Specialist co-insurance	20%
■ Hospital (facility) co-insurance	10%
■ 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$10
Co-insurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$760

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