

**Automobile Mechanics' Local #701 Welfare Fund
Premier Plan Schedule of Benefits (2023 Edition)**

Comprehensive Medical Benefit (Active Employees and their Dependents)	
Deductibles	
• Calendar Year Deductible	\$500 per person; \$1,500 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 Maximums²	
• PPO	
– Major Medical	\$5,000 per person; \$10,000 per family
– Prescription Drug ³	\$4,100 per person; \$8,200 per family
• Additional Non-PPO Maximum	\$3,000 per person; \$11,300 per family
Calendar Year Plan Maximums	
• Chiropractic/Spinal Care	12 visits per person
• Rehabilitative Physical Therapy	20 visits per person ⁴
• Rehabilitative Speech Therapy (to restore normal speech)	30 visits per person
• Habilitative outpatient Physical and Speech therapy	30 visits for Speech Therapy or 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 ⁵	\$10,000 per person per lifetime

¹ If you are a newly organized Employee, you may be able to use amounts 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 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/Valenz Care prior to receiving treatment.

⁵ Expenses to determine Infertility are not included under the lifetime maximum.

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 and Hospital Inpatient Services	Plan pays 80%	Plan pays 65%
• Emergency Room or Emergency Services for an Emergency Medical Condition	Plan pays 80% after \$400 deductible which is waived if admitted	Plan pays 80% of the lesser of the amount billed or the Qualifying Payment Amount (“QPA”) after \$400 deductible which is waived if admitted Plan pays 65% if not Emergency after \$400 deductible which is waived if admitted
• Ground Ambulance	Plan pays 80%	Plan pays 80%
• Air Ambulance	Plan pays 80%	Plan pays 80% of the lesser of the amount billed or the QPA
• Preventive Services	Plan pays 100%; no deductible	Not covered
• Non-Hospital Services (e.g., Office Visits, Lab Tests)	Plan pays 80%	Plan pays 65%
• Chiropractic ⁶	Plan pays 80% for up to 12 visits per person per calendar year	Plan pays 65% for up to 12 visits per person per calendar year
• Substance Abuse Treatment ⁷		
– Inpatient	Plan pays 90%	Plan pays 70%
– Outpatient	Plan pays 80%	Plan pays 70%
• Mental Health Treatment		
– Inpatient	Plan pays 90%	Plan pays 70%
– Outpatient	Plan pays 80%	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 80%	Not covered

⁶ Chiropractic care includes all services and supplies provided by a licensed Chiropractor.

⁷ Inpatient treatment is covered if it is provided by a Hospital or approved Residential Treatment Facility.

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• Other Covered Medical Expenses	Plan pays 80%	Plan pays 65%
• Overweight or Obesity Condition-Related Expenses ⁸	Plan pays 50%	Not covered
• Telemedicine Services	Plan pays 100% for specifically contracted services with Plan's selected vendor; no deductible	Not covered
• Imaging Procedures (CT/PET scans, MRIs)	Plan pays 100% with no deductible if the Plan's designated imaging provider is used; Plan pays 80% for non-contracted providers	Plan pays 65%
Prescription Drug Benefits (Active Employees and Dependents)		
Calendar Year Out-of-Pocket Maximum for Prescription Drugs⁹	\$4,100 per person; \$8,200 per family	
Network Retail Pharmacies	For up to a 30-day supply, you pay:	
• Generic Medication	25% (\$5 minimum/\$20 maximum)	
• Preferred Brand Drug	30% (\$25 minimum/\$100 maximum)	
• Non-Preferred Brand Drug	35% (\$31.25 minimum/\$125 maximum)	
Mail Order Service or Network Retail Pharmacies	For up to a 90-day supply, you pay:	
• Generic Medication	25% (\$15 minimum/\$60 maximum)	
• Preferred Brand Drug	30% (\$75 minimum/\$300 maximum)	
• Non-Preferred Brand Drug	35% (\$93.75 minimum/\$375 maximum)	
• Specialty Drugs	100% co-insurance. If co-insurance assistance is unavailable for a drug, the co-insurance defaults to the tiered structure shown above	

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.

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").

• Immunizations administered through the Fund's pharmacy benefits manager	Plan pays 100% (please see SPD for a list of specific covered immunizations)	
• Diabetic Testing Supplies and Syringes	Plan pays 100%	
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	
Calendar Year Deductible		
• Routine Dental Services	\$25 per person	
• All Other Covered Dental Services	None	
Copayment Percentages		
• Routine Dental Services	100%	
• Basic Dental Services	50%	
• Major Dental Services and Orthodontia	Not covered	
Vision Benefits (Active Employees and Dependents)		
	Network Provider	Non-Network Provider
Complete Eye Exam (One per calendar year)	100%; no deductible	Plan pays up to \$25 per person
Lenses and Frames or Contact Lenses (every 2 years)	Plan pays up to \$100 maximum per person every 2 years	Plan pays up to \$100 maximum per person every 2 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

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Weekly Disability Benefits (Active Employees Only)¹⁰	
Benefit Amount	\$300 per week for up to 26 weeks
Benefits Begin	First day
<ul style="list-style-type: none"> For immediate disability due to an accidental and non-occupational Injury 	First day
<ul style="list-style-type: none"> For disabilities due to non-occupational Illness 	Eighth day
Death Benefit (Active Employees and Totally Disabled Former Active Employees Only)	
Amount	\$40,000
Accidental Death & Dismemberment Benefit (Active Employees Only)	
<ul style="list-style-type: none"> 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 	\$40,000
<ul style="list-style-type: none"> One Hand One Foot Entire Sight of One Eye 	\$20,000

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.