MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

Owner Operator/Relative Shareholder Health Plan Options Comparison Chart
Effective for the Plan Year of April 1, 2024 through March 31, 2025[1]

Owner Operators / Relative Shareholders –

All benefits are subject to eligibility, maximum Plan benefit, reasonable and customary determination (or negotiated fee amounts for PPO provider services), and any special limits noted in the Plan. Charges that exceed the reasonable and customary amount or other Plan limitations will not be considered eligible in determining Plan benefits.

Special rules apply to any benefits subject to the No Surprises Act. The No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from an Out-of-Network provider at an In-Network facility. In certain circumstances, non- emergency items or services that are otherwise covered by the Plan from an Out-of-Network provider who is working at an In-Network facility are also subject to the No Surprises Act.

For benefits subject to the No Surprises Act, any cost-sharing payments count toward your In-Network deductible and In-Network Out-of-Pocket Expense Maximum. An explanation of your rights under the No Surprises Act is available at:

http://local150.org/wp-content/uploads/2022/04/NSA-Notice.pdf

Eligible expenses must be medically necessary and are subject to the Plan Year deductible unless otherwise noted. Age limitations, as specified in this Comparison Chart, are applied as of the last day of the month in which the eligible dependent's birthday occurs.

If you have any questions about your health plan options,
please contact Member Services at 708-579-6675.

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	Operators' Health Center (OHC)[2]		**Plan A**		**Platinum**		**Gold**		**Silver**		**Bronze**		**EPO**
Local 150 Primary Medical Homes (not subject to deductible) (ages vary by location) Operators' Health Center (OHC), Everside Health Centers, and Midwest Coalition of Labor Health Centers (MCL Health Centers)													
Annual/School Physical Exams, Preventive Care/Wellness Visits, Immunizations, Blood Draws, Condition Management, DOT Physicals, physical therapy at OHC locations, behavioral health services at the Countryside, IL OHC	100%		100%		100%		100%		100%		100%		100%
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network ONLY**
Medical Annual Deductible (applies to all services unless noted otherwise)													
Person	None	$300	$300	$300	$500	$1,000	$1,000	$2,000	$2,000	$4,000	$5,000	$10,000	None
Family	None	$700	$700	$700	$1,250	$2,500	$2,500	$5,000	$5,000	$10,000	$10,000	$20,000	None
Medical Out-of-Pocket Maximum (applies to all services unless noted otherwise)													
Person	$2,500	$2,500	$2,500	$2,500	$3,500	$7,000	$4,000	$8,000	$4,000	$8,000	$5,000	$10,000	$4,000
Family	$6,000	$6,000	$6,000	$6,000	$7,000	$14,000	$8,000	$16,000	$8,000	$16,000	$10,000	$20,000	$10,000
Hospital Services	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		Inpatient: $250 copay per admission Outpatient: $20 copay per visit
Emergency Services in a Hospital or Independent Freestanding Emergency Department[1]	100%[3]		90%		$100 copay; balance considered at 90%		$100 copay; balance considered at 80%		$100 copay; balance considered at 70%		$100 copay per visit		$100 copay per visit

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	Operators' Health Center (OHC)[2]		**Plan A**		**Platinum**		**Gold**		**Silver**		**Bronze**		**EPO**
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
Preventive Services[4]	100%	70%	100%	100%[5]	100%	No benefit	100%	No benefit	100%	No benefit	100%	No benefit	100%
Physician Visits	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		Primary: $20 copay per visit Specialist: $40 copay per visit
Chiropractic Services[6] (maximum of $60 per visit and 24 visits per Plan Year)	100%; HST Care Connect does not have network chiropractors at this time, so In- and Out-of-Network benefits are covered at 100%		90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Acupuncture (maximum of $125 per visit and 12 treatments per Plan Year)	100%; HST Care Connect does not have network acupuncturists at this time, so In- and Out-of-Network benefits are covered at 100%		90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Outpatient Restorative Speech Therapy	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit

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	Operators' Health Center (OHC)[2]		**Plan A**		**Platinum**		**Gold**		**Silver**		**Bronze**		**EPO**
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
Outpatient Speech Therapy	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Outpatient Speech Therapy for Developmental Conditions, including Congenital Neurological Diseases for Dependent Children Age 2 through Age 18	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Outpatient Physical and Occupational Therapy[7]	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children Age 2 through Age 18[7]	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Lab and X-ray	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		100%
Family Supplemental Benefit (per family per Plan Year)	$1,500		$1,500		$1,200		$1,000		$500		$250		$500

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	Operators' Health Center (OHC)[2]	**Plan A**	**Platinum**	**Gold**	**Silver**	**Bronze**	**EPO**
Dental Benefit							
Deductible	$0	$0	$0	$0	$0	No benefit	$0
Calendar-Year Maximum	Age 19 and older: $2,000 Under 19: no maximum	Age 19 and older: $2,000 Under 19: no maximum	Age 19 and older: $2,000 Under 19: no maximum	Age 19 and older: $2,000 Under 19: no maximum	Age 19 and older: $2,000 Under 19: no maximum	No benefit	Age 19 and older: $2,000 Under 19: no maximum
Preventive	100%	100%	100%	100%	100%	No benefit	100%
Basic and Restorative[8]	70%	70%	70%	70%	70%	No benefit	70%
Orthodontia (dependent children through age 18 only)	50%; $2,000 lifetime maximum	50%; $2,000 lifetime maximum	50%; $2,000 lifetime maximum	50%; $2,000 lifetime maximum	50%; $2,000 lifetime maximum	No benefit	50% $2,000 lifetime maximum
Death Benefit							
Member	$40,000	$40,000	$40,000	$40,000	$40,000	No benefit	$40,000
Dependent	$2,000	$2,000	$2,000	$2,000	$2,000	No benefit	$2,000
Accidental Dismemberment and Disability Benefits							
Accidental Dismemberment	$1,000 OR $5,000; based on loss; $10,000 limit for any one accident					No benefit	$1,000 OR $5,000 Based on loss $10,000 limit for any one accident
Disability Benefit	$500 per week for up to 52 weeks					No benefit	$500 per week up to 52 weeks

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	Operators' Health Center (OHC)[2]	**Plan A**	**Platinum**	**Gold**	**Silver**	**Bronze**	**EPO**
Prescription Drug Benefit							
OptumRx Network Retail Pharmacy (Short-term medication - maximum of two 30-day fills, excluding specialty drugs, then must obtain a 90-day supply)							
Generic	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay	$20 copay	$5 copay
Preferred Brand	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$40 copay	$10 copay
Non-Preferred Brand	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay	$55 copay	$25 copay
Specialty (requires a prior authorization)	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay
OptumRx Network Retail Pharmacy (90-day supply of Maintenance Medication**) & the OptumRx Home Delivery Pharmacy**							
Generic	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$50 copay	$15 copay
Preferred Brand	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay	$100 copay	$30 copay
Non-Preferred Brand	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay	$115 copay	$45 copay

Prescription Out-of-Pocket Maximum													
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network ONLY**
Person	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000	$1,600	$4,000	$2,000
Family	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000	$3,200	$8,000	$3,200
Combined Out-of-Pocket Maximum (includes both medical and prescriptions)													
Person	$4,500	$6,500	$4,500	$6,500	$5,500	$11,000	$6,000	$12,000	$6,000	$12,000	$6,600	$14,000	$6,000
Family	$10,000	$14,000	$10,000	$14,000	$11,000	$22,000	$12,000	$24,000	$12,000	$24,000	$13,200	$28,000	$13,200

1 The No Surprises Act provides patients with protection from surprise medical bills when seeking emergency services or certain services from out-of-network providers at in-network facilities. It also mandates transparency regarding healthcare costs and holds patients liable for in-network cost-sharing amounts. For more information regarding Your Rights and Protections Against Surprise Medical Bills, visit http://local150.org/wp-content/uploads/2022/04/NSA-Notice.pdf.

2 In-Network services are services available through the Operators' Health Centers (OHC), Everside Health Centers, MCL Health Centers, or HST Care Connect (network for the OHC Plan). Most Out-of-Network services will be subject to HST's negotiated Value-Based Price (VBP) amount. Out-of-Network benefits apply when services are sought outside of the OHC, Everside Health Centers or HST Care Connect.

3 Out-of-Network services are not subject to the deductible if a life-threatening emergency.

4 Not subject to deductible. For details on ACA-mandated preventive care services, visit www.healthcare.gov/coverage/preventive-care-benefits/. For details on ACA-mandated preventive care prescription drugs, visit https://local150.org/moe/benefits/healthcare/. These lists may change periodically.

5 Out-of-network preventive services are covered only for adult physical exams for member and eligible spouse and well-childcare for children up to age 2.

6 Outpatient chiropractic services are covered at 100% for all health plan options if medically necessary and received at the Rockford Everside Health Center, not subject to the deductible.

7 Outpatient physical and occupational therapy is covered at 100% for all health plan options if medically necessary and received at the Operators' Health Center or an ATI Physical Therapy facility, not subject to the deductible.

8 Coinsurance is based on Delta Dental's Allowable Fee. If you use an Out-of-Network provider, you pay the full cost of services above the Allowable Fee.

PLEASE NOTE: Absolute Solutions Imaging Network provides medically necessary MRI/CT/PET scans. Gateway Foundation and Recovery Centers of America (RCA) provide medically necessary substance abuse treatment and mental health services including but not limited to inpatient /outpatient care and residential facility. If you use these partnered vendors, all medically necessary covered services will be paid at 100%, not subject to the deductible. Primary plan rules must be followed.