EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN
SCHEDULE OF BENEFITS
MARKETPLACE (HOURLY)

Effective April 1, 2024

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 the Plan limitations will not be 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 *Schedule of Benefits*, are applied as of the last day of the month in which the eligible dependent's birthday occurs.

Local 150 Primary Medical Homes (Ages vary by location)	
Operators' Health Centers (OHC), Everside Health Centers & Midwest Coalition of Labor Health Centers (MCL Health Centers) Annual physical exam, preventive care/wellness visits, immunizations, sick visits, disease/condition management, clinical laboratory services, DOT physicals and specialty services, where available. A full list of services is available at https://local150.org/moe/local-150-primary-medical-homes-2/	100%
CVS Minute Clinics	
Non-Emergency, Unscheduled Acute Illness or Injuries Additional "cash pay" services are available at a cost to the patient	Most services covered at 100%
Medical & Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum	**In-Network *ONLY***
The amount of money applied toward the medical and pharmacy out-of-pocket maximum; it includes medical and pharmacy copayments; it does not include coinsurance for orthoptic training or temporomandibular joint disease (TMJ) treatment	$6,000 per individual $13,200 per family

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Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*
Annual Maximum Per Plan Year	Unlimited
Individual Deductible	None
Family Deductible	None
Out-of-Pocket Expense Limitation The most an individual could pay in a Plan Year for covered services. Individuals covered under Family coverage must meet their own individual out-of-pocket expense limit until the overall Family out-of-pocket expense limit has been met Does not include premiums, balance-billing charges, Family Supplemental Benefits, TMJ, orthoptic training, dental benefits, and health care not covered by the Plan	$4,000 per individual $10,000 per family
EPO Networks	BlueCross BlueShield PPO, Absolute Solutions, ATI, Gateway, Recovery Centers of America (RCA)
Inpatient Hospital Services Room allowances based on the hospital's most common semi-private room rate Pre-admission testing is covered once prior to surgery Requires approval by the Case Manager	$250 copayment per admission
Skilled Nursing Facility If recommended by a physician and confinement begins within 30 days of a hospital confinement Follow Medicare guidelines for breaks in skilled nursing facility care Maximum per disability: 45 days Requires approval by the Case Manager	$250 copayment per admission
Home Health Care If ordered by a physician Requires approval by the Case Manager	$20 copayment per visit
Outpatient Hospital Services Including licensed surgery centers Outpatient surgical procedures not performed in the doctor's office requires approval by the Case Manager	$20 copayment per visit
Emergency Services in a Hospital or Independent Freestanding Emergency Department Facility charges	$100 copayment per visit Note: Out-of-network emergency room visits are covered at the same level ($100 copayment per visit)
Diagnostic X-rays/Lab X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury	100%
MRI/CT and PET Scans	100% if you use a BCBS PPO provider or schedule through Absolution Solutions
Outpatient Physical and Occupational Therapy Must be performed by a licensed provider Requires approval by the Case Manager	100%, no copayment if received at an ATI Physical Therapy Facility; otherwise, $20 copayment per visit when a BCBS PPO provider is used
Outpatient Restorative Speech Therapy (Children and Adults) Must be performed by a licensed provider Requires approval by the Case Manager	$20 copayment per visit
Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological Diseases for individuals ages two through 18 Must be performed by a licensed provider Requires approval by the Case Manager	$20 copayment per visit

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Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for individuals through age 18 only Must be performed by a licensed provider Requires approval by the Case Manager	100%, no copayment if received at an ATI Physical Therapy Facility; otherwise, $20 copayment per visit when a BCBS PPO provider is used
Orthoptic Training For dependent children up to age 10 only Training needs to be prescribed by a covered provider Lifetime maximum: 40 visits Does not count toward the medical & prescription drug benefit combined out-of-pocket expense maximum or the medical benefit out-of-pocket expense limitation; if you reach an out-of-pocket maximum, you will continue to pay 50% coinsurance for orthoptic training services; the Plan will not pay 100% for orthoptic training services after you reach a benefit out-of-pocket maximum Requires approval by the Case Manager	50%
Physician's Medical/Surgical Care Office visits, hospital visits, surgery, assistant surgeon, etc. Certain procedures performed in the physician's office may require approval by the Case Manager	Primary Care: $20 copayment per visit Specialist: $40 copayment per visit
Preventive Care, including Well Woman and Well Child Care Includes routine physical exams, routine labs, routine outpatient visits and immunizations Refer to **https://www.healthcare.gov/coverage/preventive-care-benefits/** for more information and the list of current ACA-required preventive service	100% subject to ACA guidelines
Chiropractic Services Limit of $60 per visit and 24 visits per Plan Year	$20 copayment per visit
Durable Medical Equipment Rental paid up to purchase price of the equipment, except for lifetime items that do not have a purchase price Includes necessary adjustments or repairs, or replacement, if more cost effective Electric wheelchair limited to $15,000 Requires approval by the Case Manager on equipment over $1,000	80%
Foot Orthotics Custom-fitted foot orthotics prescribed by a physician Plan Year maximum: $350 Lifetime maximum: $2,000	80%
Prosthetic Devices Artificial devices to restore a normal body function Requires approval by the Case Manager	80%

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Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*
Transplants Available to all non-Medicare-eligible members and dependents *If Medicare is primary, Medicare-eligible members and dependents must use Medicare-approved providers* Benefit begins five days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure Transportation and lodging maximum: $10,000 Private duty nursing maximum: $10,000 Requires approval by the Case Manager	Follows inpatient, outpatient, and physician copayments
Orthodontic Treatment of Temporomandibular Joint Disease (TMJ) Oral Appliance Not subject to the deductible or out-of-pocket maximums Lifetime maximum: $4,000 Requires approval by the Case Manager	50%
Cochlear Implants Requires approval by the Case Manager	Follows inpatient, outpatient, and physician copayments
Medical Transportation Includes ground and air transport from the site of the injury, medical emergency, or acute illness to the nearest facility Includes ground non-emergency transfer from hospital to home hospice care if home is less than 100 miles from hospital Inter-health-care-facility transfer maximum: $5,000	80%
Acupuncture Services performed by a licensed provider within the scope of his or her license Maximum of 12 treatments per Plan Year Up to $125 allowable per visit	$20 copayment per visit
Sleep Apnea Appliance When ordered by a physician and provided by a medical equipment supplier or dentist Appliance replacement once every five years if existing appliance is covered Requires approval by the Case Manager	80%
Mental Illness and Substance Abuse	**In-Network *ONLY***
Mental Health and Substance Abuse Network	BlueCross BlueShield PPO, Gateway, RCA
Inpatient Care Requires approval by the Case Manager	100%, not subject to co-payment if received at Gateway/RCA Facility; otherwise, $250 copayment per admission
Outpatient Care ABA Therapy, IOP and PHP requires approval by the Case Manager	100%, not subject to co-payment if received at Gateway/RCA Facility; otherwise, $20 copayment per visit
Residential Facility Requires approval by the Case Manager	100%, not subject to co-payment if received at Gateway/RCA Facility; otherwise, $250 copayment per admission

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Member Assistance Program (MAP) Administered by Employee Resource System (ERS)	Provides members and covered dependents with up to five no-cost visits per episode per Plan Year Additional counseling or treatment may require payment	
Dental Benefit	**In-Network**	**Out-of-Network**
Dental PPO Network and Claims Administration	Delta Dental PPO	Not applicable If you use a non-network dentist, Delta Dental will pay you directly, leaving you responsible to pay the provider
Deductible	$0	
Plan Year Maximum No maximum for children under age 19	$2,000 per adult (age 19 and older)	
Preventive	100%	
Basic and Major Services Fillings, crowns, root canal therapy, oral surgery, dentures, bridgework, and other covered dental services	70% coinsurance is based on Delta Dental's Allowable Fee You pay the full cost of services above the Allowable Fee if you use an Out-of-Network provider	
Orthodontia Dependent children through age 18 only Lifetime maximum: $2,000	50% coinsurance is based on Delta Dental's Allowable Fee You pay the full cost of services above the Allowable Fee if you use an Out-of-Network provider	
Disability Benefit		
Available to members only	$500 per week for up to 52 weeks Eligibility is credited with 40 hours a week for up to 17 weeks	
Death Benefit		
Available to members and eligible dependents	$40,000 per eligible member $2,000 per eligible dependent	
Accidental Dismemberment Benefit		
Available to members only	$1,000 or $5,000 based on type of loss Limited to $10,000 for any one accident	
Family Supplemental Benefit		
This benefit can be used for non-covered medically necessary and un-reimbursed medical, dental and pharmacy benefit expenses, including items such as hearing aids, glasses, etc. It cannot be used to reimburse expenses covered under the prescription drug program Reimbursement for Plan maximums and items covered at 50% that are not subject to the out-of-pocket maximum are eligible Other than stated above, this benefit cannot be used to reimburse the deductible, copayment, or amount over the reasonable and customary amount	Maximum per family, per Plan Year: $2,000	

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Prescription Drug Program

Prescription drug benefits will be paid for prescriptions on the OptumRx Select Formulary when filled at a pharmacy in the Pharmacy Benefit Manager's (PBM's) network

Long-term medications (Maintenance drugs) must be filled at a CVS retail pharmacy or through the OptumRx Home Delivery Pharmacy

Medical deductible does not apply for prescription drugs

No coordination of benefits applies

Specialty medications must be filled through the Optum Specialty Pharmacy; specialty medications are limited to a 30-day fill

No coverage for out-of-network pharmacies until you reach your out-of-pocket maximum as noted below; once the out-of-pocket maximum is met, prescriptions will be paid at 100%

Medication used to treat Cancer and transplant medications billed by OptumRx are subject to the following 4-tier structure

	In-Network *ONLY*	
	OptumRx Network Retail Pharmacy (up to two 30-day fills)	**CVS retail pharmacy or OptumRx Home Delivery (up to a 90-day fill)**
Generic Drug (Tier 1)	$5 copayment(1) for a 30-day supply	$15 copayment(1) for a 90-day supply
Preferred Brand Name Drug (Tier 2)	$10 copayment(1) for a 30-day supply	$30 copayment(1) for a 90-day supply
Non-Preferred Brand Name Drug (Tier 3)	$25 copayment(1) for a 30-day supply	$45 copayment(1) for a 90-day supply
Specialty Drug (Tier 4) Requires authorization	$100 copayment(1) for a 30-day supply	Not applicable
Pharmacy Out-of-Pocket Maximum	$2,000 per individual $3,200 per family	
Compounded Drugs (A minimum of one ingredient must be covered under the prescription drug program)	Prescriptions exceeding $300 require authorization	
Convalescent or Nursing Home(2)	Follows the above copayment structure	

(1) Copayments listed are the Plan's basic copayment schedule; if the cost of the medication is less than the copayment listed, you will be responsible for paying the lower cost.

(2) If the Convalescent or Nursing Home is Out-of-Network, the patient will incur 50% of the cost of the medication.

Limitations & Exceptions

Maximum of up to two 30-day supplies of the same medication, can be filled at any local in-network pharmacy before you are required to obtain a 90-day supply. If you are seeking a third refill, you must transition to a CVS retail pharmacy or the OptumRx Home Delivery Pharmacy or pay 100% of the cost of the prescription drug. Please call OptumRx at (855) 697-9150 or visit **www.optumrx.com** for more information.

When available, generic drugs will be substituted for all brand name drugs or medications. If you request a brand name drug, or if the prescribing physician indicates "no substitutions," when a generic equivalent is available, you will be required to pay the brand name drug copayment plus the difference in cost between the brand name drug and its generic equivalent unless determined medically necessary through the appeals process.

*For a list of no-cost preventive medications, visit **https://local150.org/moe/prescription-drug-program/prescription-benefit-active-members-and-non-medicare-retirees/**.*