OPERATORS' HEALTH CENTER (OHC) 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.

In-network services are services available at Local 150 Primary Medical Homes (Operators' Health Centers (OHC), Everside Health Centers, Midwest Coalition of Labor Health Centers (MCL Health Centers)), CVS Minute Clinics, ATI, Absolute Solutions, Gateway, Recovery Centers of America (RCA) or HST Care Connect (network for the OHC Plan). **If you are unable to locate an in-network provider, please contact a specialized OHC Plan Representative at (708) 579-6668 for assistance or visit https://moefunds.hstechnology.com/.**

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, MCL Health Centers, CVS Minute Clinics, ATI, Absolute Solutions, Gateway, Recovery Centers of America (RCA) or the HST Care Connect.

Value-Based Pricing is a transparent way of determining how much a provider or facility will be paid for certain services. It works by reimbursing the provider or facility based on a reference price. Because it is fully transparent and based on costs, the result is a price that is fair to both the provider or facility and the patient. For example, the referenced price uses the cost Medicare would pay for a service plus a negotiated percentage, such as 160%. If you have a routine doctor's visit and Medicare pays $50 for that visit, the referenced price could be $80 ($50 x 1.60).

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Local 150 Primary Medical Homes (Ages vary by location)		
Operators' Health Centers (OHC), Everside 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. See a full list of services available at: https://local150.org/moe/local-150-primary-medical-homes-2/ Not subject to deductible	100%	
CVS Minute Clinics		
Non-Emergency, Unscheduled Acute Illness, or Injuries Additional "cash pay" services are available at a cost to the patient Not subject to the deductible	Most services covered at 100%	
Medical & Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum	**In-Network ONLY**	**Out-of-Network**
The amount of money applied toward the medical and pharmacy out-of-pocket maximum; it includes medical deductible and pharmacy copayments	$4,500 per individual $10,000 per family	$6,500 per individual $14,000 per family
Medical Benefit (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Annual Maximum Per Plan Year	Unlimited	
Individual Deductible Per person, per Plan Year All out-of-network benefits are subject to the deductible unless otherwise noted The three-month carryover applies	$0	$300
Family Deductible Per Plan Year All out-of-network benefits are subject to the deductible unless otherwise noted The three-month carryover does not apply	$0	$700
Out-of-Pocket Expense Limitation The most an individual could pay in a Plan Year for covered services, including the deductible. For out-of-network services, individuals covered under Family coverage must meet their own individual out-of-network out-of-pocket expense limit until the overall Family out-of-network out-of-pocket expense limit has been met Does not include premiums, balance-billing charges, Family Supplemental Benefits, dental benefits, and health care not covered by the Plan	$2,500 per individual $6,000 per family	$2,500 per individual $6,000 per family

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Medical Benefit (Comprehensive Medical Benefit)	In-Network	Out-of-Network
VBP Plan Networks	HST Care Connect, Absolute Solutions, ATI, Gateway, Recovery Centers of America (RCA)	Not applicable
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	100%	70% of negotiated amount
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 HST Care Connect does not contract with Skilled Nursing Facilities Maximum per disability: 45 days Requires approval by the Case Manager	100% of negotiated amount, deductible does not apply	
Home Health Care If ordered by a physician Requires approval by the Case Manager	100%	70% of negotiated amount
Outpatient Hospital Services Including licensed surgery centers Outpatient surgical procedures not performed in the doctor's office require approval by the Case Manager	100%	70% of negotiated amount
Emergency Services in a Hospital or Independent Freestanding Emergency Department Facility and professional charges Life-threatening emergencies only. If not life-threatening, out-of-network deductibles and additional copayments may apply	100%	100% of negotiated amount with no deductible for a life-threatening emergency; otherwise, 70% of negotiated amount
Diagnostic X-rays/Lab X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury	100%	70% of negotiated amount
MRI/CT and PET Scans	100% if you use an HST Care Connect provider or schedule through Absolute Solutions	70% of negotiated amount
Outpatient Physical and Occupational Therapy Must be performed by a licensed provider Requires approval by the Case Manager	100%, if received at an ATI Physical Therapy Facility or when an HST Care Connect provider is used	70% of negotiated amount
Outpatient Restorative Speech Therapy (Children and Adults) Must be performed by a licensed provider Requires approval by the Case Manager	100%	70% of negotiated amount

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Medical Benefit (Comprehensive Medical Benefit)	In-Network	Out-of-Network
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	100%	70% of negotiated amount
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%, if received at an ATI Physical Therapy Facility or when an HST Care Connect provider is used	70% of negotiated amount
Orthoptic Training For dependent children up to age 10 only Training needs to be prescribed by a covered provider Lifetime maximum: 40 visits Not subject to the deductible Requires approval by the Case Manager	100%	70% of negotiated amount
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 If you receive services in an HST Care Connect facility from a provider not aligned with HST Care Connect the benefit will be payable at 100%	100%	70% of negotiated amount
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 services	100%	70% of negotiated amount
Chiropractic Services Limit of $60 per visit and 24 visits per Plan Year HST Care Connect does not contract with chiropractors	100% of negotiated amount, deductible does not apply	
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 Requires approval by the Case Manager on equipment over $1,000	100% of negotiated amount, deductible does not apply	
Foot Orthotics Custom-fitted foot orthotics prescribed by a physician Plan Year maximum: $350 Lifetime maximum: $2,000	100%	70% of negotiated amount

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Medical Benefit (Comprehensive Medical Benefit)	In-Network	Out-of-Network
Prosthetic Devices Artificial devices to restore a normal body function Requires approval by the Case Manager	100%	70% of negotiated amount
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 For transplants that HST Care Connect does not perform, you will be referred to a non-HST Care Connect facility; Benefits will be payable at 100% of the VBP amount Transportation and lodging maximum: $10,000 Private duty nursing maximum: $10,000 Requires approval by the Case Manager	100%	Not covered
Orthodontic Treatment of Temporomandibular Joint Disease (TMJ) Oral Appliance Lifetime maximum: $4,000 Not subject to the deductible or out-of-pocket maximums Requires approval by the Case Manager	100% of negotiated amount, deductible does not apply	
Cochlear Implants Requires approval by the Case Manager	100%	Not covered
Medical Transportation Includes ground and air transport from the site of the injury, medical emergency, or acute illness to the nearest facility Life-threatening emergencies only. If not life-threatening, out-of-network deductibles and additional copayments may apply 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	100%	100% of the greater of the negotiated amount or the reasonable and customary charge
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 HST Care Connect does not contract with acupuncturists	100% of negotiated amount, deductible does not apply	
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	100% of negotiated amount, deductible does not apply	

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Mental Illness and Substance Abuse	In-Network	Out-of-Network
Mental Health and Substance Abuse Network	HST Care Connect, Gateway, RCA	Not applicable
Inpatient Care Requires approval by the Case Manager	100% of negotiated amount, deductible does not apply	
Outpatient Care ABA Therapy, IOP and PHP requires approval by the Case Manager	100% of negotiated amount, deductible does not apply	
Residential Facility Requires approval by the Case Manager	100% of negotiated amount, deductible does not apply	
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 Benefits	**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, transplant medications, and IV infusions billed by OptumRx are subject to the following 4-tier structure

	In-Network		Out-of-Network
	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	Not covered
Preferred Brand Name Drug (Tier 2)	$10 copayment(1) for a 30-day supply	$30 copayment(1) for a 90-day supply	Not covered
Non-Preferred Brand Name Drug (Tier 3)	$25 copayment(1) for a 30-day supply	$45 copayment(1) for a 90-day supply	Not covered
Specialty Drug (Tier 4) Requires authorization	$100 copayment(1) for a 30-day supply	Not applicable	Not covered
Pharmacy Out-of-Pocket Maximum	$2,000 per individual $4,000 per family		$4,000 per individual $8,000 per family
Compounded Drugs (A minimum of one ingredient must be covered under the prescription drug program)	Prescriptions exceeding $300 require authorization		Not covered
Convalescent or Nursing Home	Follows the above copayment structure		50% of the cost of the medication

(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.

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/.***