



MIDWEST OPERATING ENGINEERS  
FRINGE BENEFIT FUNDS

# Schedule Of *Benefits*



MOE HEALTH PLAN MARKETPLACE  
BRONZE PLAN

A Schedule of Benefits explains what services are covered, the associated costs like copays, deductibles, and coinsurance, and any limitations or exclusions that are included, to give you an idea of what you're going to pay for medical treatments and procedures.

Plans' benefits are subject to eligibility, maximum Plan benefits, reasonable and customary determinations (or negotiated fees for PPO dental 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. To avoid additional out-of-pocket costs, be sure to utilize in-network providers.

**What is a Reasonable and Customary Charge?**  
Actual charge for the service or supply is comparable to what is usually charged for the same service or supply in the provider's geographic area.

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 are applied as of the last day of the month in which the eligible dependent's birthday occurs.

<b>Comprehensive Medical Expense Benefits</b>	
<b>Local 150 Health Centers – Not subject to deductible</b>	
<b>Operators' Health Centers (OHC), Marathon Health Centers &amp; Midwest Coalition of Labor Health Centers (MCL Health Centers)</b> Services include annual physical exams, preventive care/wellness visits, immunizations, sick visits, chiropractic services, physical therapy, behavioral health, disease/condition management, clinical laboratory services, DOT physicals, specialty services, and more. Patient age requirements and services vary by location. Visit <a href="https://local150.org/moe/local-150-health-centers/">https://local150.org/moe/local-150-health-centers/</a> .	<b>100%</b>
<b>MinuteClinic – Not subject to the deductible</b>	
Located in select CVS and Target locations. Non-emergency, unscheduled acute illness, or injuries. Additional "cash pay" services are available at a cost to the patient.	<b>Most services covered at 100%</b>

<b>Medical &amp; Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum</b>	<b>In-Network</b>	<b>Out-of-Network</b>
The amount of money applied toward the medical and pharmacy out-of-pocket maximum; it includes medical deductible and pharmacy copayments; it does not include coinsurance for orthoptic training or temporomandibular joint disease (TMJ) treatment	<b>\$6,600 per individual \$13,200 per family</b>	<b>\$14,000 per individual \$28,000 per family</b>
<b>Medical Out-of-Pocket Expense Maximum</b>		
The most an individual could pay in a Plan Year for covered services, including the deductible. 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.	<b>\$5,000 per individual \$10,000 per family</b>	<b>\$10,000 per individual \$20,000 per family</b>
<b>Medical Benefits – Comprehensive Medical Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Annual Maximum</b> Per Plan Year.	<b>Unlimited</b>	
<b>Individual Deductible</b> Per person, per Plan Year. All benefits are subject to the deductible unless otherwise noted. Three-month (4 <sup>th</sup> quarter) carryover applies – Covered Expenses applied against the Individual Deductible in the last three months of a Plan Year may also be applied to the next Plan Year.	<b>\$5,000</b>	<b>\$10,000</b>
<b>Family Deductible</b> Per Plan Year. Three-month (4 <sup>th</sup> quarter) carryover does not apply. In-network and out-of-network deductibles are separate and will not cross apply.	<b>\$10,000</b>	<b>\$20,000</b>
<b>PPO Networks &amp; Exclusive Partnerships</b>	<b>BlueCross BlueShield PPO, Absolute Solutions, ATI Physical Therapy, Gateway, and Recovery Centers of America (RCA)</b>	<b>Not Applicable</b>
<b>Inpatient Hospital Services</b> Room allowances based on the hospital's most common semi-private room rate. Pre-admission testing is covered one time prior to surgery. Requires approval by the Case Manager.	<b>100%</b>	
<b>Emergency Services in a Hospital or Independent Freestanding Emergency Department</b> Facility charges.	<b>\$100 copayment per visit</b>	

Medical Benefits – Comprehensive Medical Benefit	In-Network	Out-of-Network
<b>Skilled Nursing Facility</b> 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.	100%	
<b>Home Health Care</b> If ordered by a physician. Requires approval by the Case Manager.	100%	
<b>Outpatient Hospital Services</b> Including licensed surgery centers. Outpatient surgical procedures require approval by the Case Manager unless performed in the doctor's office without anesthesia.	100%	
<b>Diagnostic X-rays/Lab</b> X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury.	100%	
<b>MRI/CT and PET Scans</b> Services will be covered at 100% and not subject to the deductible if scheduled through Absolute Solutions.	100%	
<b>Outpatient Physical and Occupational Therapy</b> Must be performed by a licensed provider. Services will be covered at 100% and not subject to the deductible if received at a Local 150 Health Center or an ATI Physical Therapy Facility. Requires approval by the Case Manager.	100% after the deductible	100%
<b>Outpatient Restorative Speech Therapy (Children and Adults)</b> Must be performed by a licensed provider. Requires approval by the Case Manager.	100%	
<b>Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases</b> Must be performed by a licensed provider. Requires approval by the Case Manager.	100%	
<b>Orthoptic Training</b> - Not subject to the deductible or out-of-pocket maximums. Training needs to be prescribed by a covered provider. 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%	
<b>Physician's Medical/Surgical Care</b> Office visits, hospital visits, surgery, assistant surgeon, etc. Certain procedures performed in the physician's office may require approval by the Case Manager.	100%	

Medical Benefits – Comprehensive Medical Benefit	In-Network	Out-of-Network
<b>Preventive Care, including Well Woman and Well Child Care</b> – Not subject to the deductible. Includes routine physical exams, routine labs, routine outpatient visits, routine hearing exams, mammograms, and immunizations.	100%	Not covered
<b>Chiropractic Services</b> Limited to 24 visits per year with a \$60 maximum per visit. Services will be covered at 100% and not subject to the deductible if received at a Local 150 Health Center.	100%	
<b>Durable Medical Equipment (DME)</b> 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. Power wheelchair limited to \$15,000. Requires approval by the Case Manager on equipment over \$1,000.	100%	
<b>Foot Orthotics</b> Custom fitted foot orthotics prescribed by a physician. Lifetime maximum: \$2,000.	100%	
<b>Prosthetic Devices</b> Artificial devices to restore a normal body function. Requires approval by the Case Manager.	100%	
<b>Transplants</b> Available to all non-Medicare members and dependents. <i>If Medicare is primary, Medicare-eligible members and dependents must use Medicare-approved providers</i> Benefit begins five days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure. Private duty nursing maximum: \$10,000. Requires approval by the Case Manager.	100%	Not covered
<b>Transplant Lodging</b> - Not subject to the deductible. No copayments or coinsurance are applicable. Transportation and lodging maximum: \$10,000 within the 18-month transplant period for the initial transplant.	100% (network not applicable for this benefit)	
<b>Orthodontic Treatment of Temporomandibular Joint Disease (TMJ) Oral Appliance</b> – Not subject to the deductible or out-of-pocket maximums. 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 TMJ services; the Plan will not pay 100% for TMJ services after you reach a benefit out-of-pocket maximum Lifetime maximum: \$4,000. Requires approval by the Case Manager.	50%	

Medical Benefits – Comprehensive Medical Benefit	In-Network	Out-of-Network
<b>Cochlear Implants</b> Requires approval by the Case Manager.	100%	Not covered
<b>Medical Transportation</b> 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 hospice care if home is less than 100 miles from hospital. Inter-health-care-facility transfer maximum: \$5,000.	100%	
<b>Acupuncture</b> 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.	100%	
<b>Sleep Apnea Appliance</b> 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%	
<b>Mental Health and Substance Use</b> – Subject to the deductible	In-Network	Out-of-Network
<b>Mental Health and Substance Use Network</b>	BlueCross Blue Shield PPO, Gateway, and Recovery Centers of America (RCA)	Not applicable
<b>Inpatient Care</b> Services will be covered at 100% and not subject to the deductible if received at a Gateway or RCA facility. Requires approval by the Case Manager.	100%	
<b>Outpatient Care</b> Services will be covered at 100% and not subject to the deductible if received at a Gateway or RCA facility. ABA Therapy, IOP, and PHP requires approval by the Case Manager.	100%	
<b>Residential Facility</b> Services will be covered at 100% and not subject to the deductible if received at a Gateway or RCA facility. Requires approval by the Case Manager.	100%	
<b>Member Assistance Program (MAP)</b> Administered by AllOne Health.	Provides members and covered dependents with up to five no-cost visits per episode per Plan Year.  Additional counseling or treatment may require payment.	
<b>Family Supplemental Benefit (FSB)</b>	Coverage	
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%	Maximum per family, per Plan Year: \$2,000	

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.

For additional information regarding reimbursable and non-reimbursable FSB expenses, please visit

<https://local150.org/moe/family-supplemental-benefit/>.

**This health plan option does not provide benefits for:**

- **Dental**
- **Accidental Dismemberment**
  - **If the member is in good standing, supplemental Accidental Dismemberment can be purchased through the National Coalition of Labor (visit [coalitionoflabor.org](https://coalitionoflabor.org) for more information).**
- **Death**
- **Short-Term Disability**

