MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

# Schedule Of Benefits

## MUNICIPALITY OHC PLAN

MIDWEST OPERATING ENGINEERS FRINGE BENEFIT FUNDS

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, in order 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.

**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.

In-network services are services available at Local 150 Health Centers (Operators' Health Centers (OHC), Marathon Health Centers, Midwest Coalition of Labor Health Centers (MCL Health Centers)), CVS Minute Clinics, ATI Physical Therapy, Absolute Solutions, Gateway, Recovery Centers of America (RCA) or HST Care Connect (network for the OHC Plan). **To locate an in-network provider, please contact a specialized OHC Plan Representative at (708) 579-6668 for assistance or visit https://www.hstconnect.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 received outside of the OHC, Marathon Health Centers, MCL Health Centers, CVS Minute Clinics, ATI Physical Therapy locations, Absolute Solutions, Gateway, RCA, or 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 end 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).

| | | |
|---|---|---|
| **Local 150 Health Centers** – Not subject to deductible | | |
| **Operators' Health Centers (OHC), Marathon Health Centers & Midwest Coalition of Labor Health Centers (MCL Health Centers)**<br>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.<br>Patient age requirements and services vary by location.<br>Visit https://local150.org/moe/local-150-health-centers/. | **100%** | |
| **MinuteClinic** – Not subject to the deductible | | |
| Located in select CVS and Target locations.<br>Non-emergency, unscheduled acute illness, or injuries.<br>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** | **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<br>$10,000 per family** | **$6,500 per individual<br>$14,000 per family** |
| **Medical Out-of-Pocket Expense Maximum** | | |
| 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.<br>Does not include premiums, balance-billing charges, Family Supplemental Benefits, dental benefits, and health care not covered by the Plan. | **$2,500 per individual<br>$6,000 per family** | **$2,500 per individual<br>$6,000 per family** |
| **Medical Benefits – Comprehensive Medical Benefit** | **In-Network** | **Out-of-Network** |
| **Annual Maximum**<br>Per Plan Year. | **Unlimited** | |
| **Individual Deductible**<br>Per person, per Plan Year.<br>All out-of-network benefits are subject to the deductible unless otherwise noted.<br>Three-month (4th quarter) carryover applies – Covered Expenses applied against the Individual Deductible in the last three months of a Plan Year may also be applied for the next Plan Year. | **$0** | **$300** |
| **Family Deductible**<br>Per Plan Year.<br>Three-month (4th quarter) carryover does not apply. | **$0** | **$700** |

| Medical Benefits – Comprehensive Medical Benefit | In-Network | Out-of-Network |
|---|---|---|
| **VBP Plan Networks & Exclusive Partnerships** | HST Care Connect, Absolute Solutions, ATI Physical Therapy, Gateway, Recovery Centers of America (RCA) | Not Applicable |
| **Inpatient Hospital Services**<br>Room allowances based on the hospital's most common semi-private room rate.<br>Pre-admission testing is covered one time prior to surgery.<br>Requires approval by the Case Manager. | **100%** | **70% of negotiated amount** |
| **Emergency Services in a Hospital or Independent Freestanding Emergency Department**<br>Facility and professional charges.<br>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** |
| **Skilled Nursing Facility**<br>If recommended by a physician and confinement begins within 30-days of a hospital confinement.<br>Follow Medicare guidelines for breaks in skilled nursing facility care<br>HST Care Connect does not contract with Skilled Nursing Facilities<br>Maximum per disability: 45 days.<br>Requires approval by the Case Manager. | **100% of negotiated amount, deductible does not apply** | |
| **Home Health Care**<br>If ordered by a physician.<br>Requires approval by the Case Manager. | **100%** | **70% of negotiated amount** |
| **Outpatient Hospital Services**<br>Including licensed surgery centers.<br>Outpatient surgical procedures require approval by the Case Manager unless performed in the doctor's office without anesthesia. | **100%** | **70% of negotiated amount** |
| **Diagnostic X-rays/Lab**<br>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 Scans** | **100% if you use an HST Care Connect provider or schedule through Absolute Solutions** | **70% of negotiated amount** |
| **PET Scans**<br>Services will be covered at 100% and not subject to the deductible if scheduled through Absolute Solutions. | **100%** | **70% of negotiated amount** |

| Medical Benefits – Comprehensive Medical Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient Physical and Occupational Therapy**<br>Must be performed by a licensed provider.<br>Requires approval by the Case Manager. | **100%, if received at a Local 150 Health Center, ATI Physical Therapy Facility, or when an HST Care Connect provider is used** | **70% of negotiated amount** |
| **Outpatient Restorative Speech Therapy (Children and Adults)**<br>Must be performed by a licensed provider.<br>Requires approval by the Case Manager. | **100%** | **70% of negotiated amount** |
| **Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases**<br>Must be performed by a licensed provider.<br>Requires approval by the Case Manager. | **100%** | **70% of negotiated amount** |
| **Orthoptic Training** – Not subject to the deductible or out-of-pocket maximums.<br>Training needs to be prescribed by a covered provider.<br>Requires approval by the Case Manager. | **100%** | **70% of negotiated amount** |
| **Physician's Medical/Surgical Care**<br>Office visits, hospital visits, surgery, assistant surgeon, etc.<br>Certain procedures performed in the physician's office may require approval by the Case Manager.<br>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** – Not subject to the deductible.<br>Includes routine physical exams, routine lab, routine outpatient visits, routine hearing exams, mammograms, and immunizations. | **100%** | **70% of negotiated amount** |
| **Chiropractic Services**<br>Limited to 24 visits per year with a $60 maximum per visit.<br>HST Care Connect does not contract with chiropractors.<br>Services will be covered at 100% and not subject to the deductible if received at a Local 150 Health Center. | **100% of negotiated amount, deductible does not apply** | |
| **Durable Medical Equipment (DME)**<br>Rental paid up to purchase price of the equipment, except for lifetime items that do not have a purchase price.<br>Includes necessary adjustments or repairs, or replacement, if more cost effective.<br>Requires approval by the Case Manager on equipment over $1,000. | **100% of negotiated amount, deductible does not apply** | |
| **Foot Orthotics**<br>Custom fitted foot orthotics prescribed by a physician.<br>Lifetime maximum: $2,000. | **100%** | **70% of negotiated amount** |
| **Prosthetic Devices**<br>Artificial devices to restore a normal body function.<br>Requires approval by the Case Manager. | **100%** | **70% of negotiated amount** |

| Medical Benefits – Comprehensive Medical Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Transplants**<br>Available to all non-Medicare members.<br>If Medicare is primary, Medicare-eligible members and dependents must use Medicare-approved providers<br>Benefit begins five days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.<br>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<br>Private duty nursing maximum: $10,000.<br>Requires approval by the Case Manager. | **100%** | **Not Covered** |
| **Transplant Lodging** – Not subject to the deductible. No copayments or coinsurance are applicable<br>Transportation and lodging maximum: $10,000 within the 18-month transplant period for the initial transplant. | **100%**<br>(network not applicable for this benefit) | |
| **Orthodontic Treatment of Temporomandibular Joint Disease (TMJ) Oral Appliance** – Not subject to the deductible or out-of-pocket maximums.<br>Lifetime maximum: $4,000.<br>HST Care Connect does not contract with dentists.<br>Requires approval by the Case Manager. | **100% of negotiated amount, deductible does not apply** | |
| **Cochlear Implants**<br>Requires approval by the Case Manager. | **100%** | **Not Covered** |
| **Medical Transportation**<br>Includes ground and air transport from the site of the injury, medical emergency, or acute illness to the nearest facility.<br>Life-threatening emergencies only. If not life- threatening, out-of-network deductibles and additional copayments may apply.<br>Includes ground non-emergency transfer from hospital to hospice care if home is less than 100 miles from hospital.<br>Inter-health-care-facility transfer maximum: $5,000. | **100%** | **100% of the greater of the negotiated amount or the reasonable and customary charge** |
| **Acupuncture**<br>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.<br>HST Care Connect does not contract with acupuncturists. | **100% of negotiated amount, deductible does not apply** | |
| **Sleep Apnea Appliance**<br>When ordered by a physician and provided by a medical equipment supplier or dentist.<br>Appliance replacement once every five years if existing appliance is covered.<br>Requires approval by the Case Manager. | **100% of negotiated amount, deductible does not apply** | |

| Mental Health and Substance Use | In-Network | Out-of-Network |
|---|---|---|
| **Mental Health and Substance Use Network** | **HST Care Connect, Gateway, Recovery Centers of America (RCA)** | **Not Applicable** |
| **Inpatient Care**<br>Requires approval by the Case Manager. | **100% of negotiated amount, deductible does not apply** | |
| **Outpatient Care**<br>ABA Therapy, IOP, and PHP requires approval by the Case Manager. | **100% of negotiated amount, deductible does not apply** | |
| **Residential Facility**<br>Requires approval by the Case Manager. | **100% of negotiated amount, deductible does not apply** | |
| **Member Assistance Program (MAP)**<br>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. | |
| **Short-Term Disability Benefit** | | |
| Available to members only | $500 per week for the first 30 days of disability (prorated for any paid days off) | |
| **Death Benefit** | | |
| Available to members and eligible dependent(s) | $40,000 per eligible member<br>$2,000 per eligible dependent | |
| **Accidental Dismemberment Benefit** | | |
| Available to members only | $1,000 or $5,000 based on type of loss<br>Limited to $10,000 for any one accident | |
| **Family Supplemental Benefit (FSB)** | **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.<br>Reimbursement for Plan maximums and items covered at 50% that are not subject to the out-of-pocket maximum are eligible.<br>Other than stated above, this benefit cannot be used to reimburse the deductible, copayment, or amount over the reasonable and customary amount.<br>For additional information regarding reimbursable and non-reimbursable FSB expenses, please visit<br>https://local150.org/moe/family-supplemental-benefit/ | Maximum per family, per Plan Year: $1,500 | |

| Dental Benefits | In-Network | Out-of-Network |
|---|---|---|
| **PPO Network and Claims Administration** | Delta Dental PPO | Not applicable.<br>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**<br>No maximum for children under the age of 19. | **$2,000 per adult (age 19 and older)** | |
| **Preventative** | **100%** | |

| Dental Benefits | In-Network | Out-of-Network |
|---|---|---|
| **Basic and Restorative**<br>Fillings, crowns, root canal therapy, oral surgery, dentures, bridgework, and other covered dental services. | 70% coinsurance is based on Delta Dental's Allowable Fee<br>You pay the full cost of services above the Allowable Fee if you use an Out-of-Network provider. | |
| **Orthodontia**<br>Dependent children through age 18 only.<br>Lifetime maximum: $2,000. | 50% coinsurance is based on Delta Dental's Allowable Fee.<br>You pay the full cost of services above the Allowable Fee if you use an Out-of-Network provider. | |

**Prescription Drug Coverage**

Prescription drug benefits will be paid for prescriptions on the CVS Caremark Formulary when filled at a pharmacy in the CVS Caremark network.

Long-term medications (Maintenance drugs) must be filled at a CVS retail pharmacy or through the CVS Caremark Mail Service Pharmacy.

Some covered medications may require a Prior Authorization or Step Therapy or may have Quantity Limits. To find out if your medication has any additional requirements or limits, refer to the Commercial Plan Drug List.

Copays listed below are the Plan's basic 4-tier copay schedule; if the cost of the medication is less than the copay listed, you will be responsible for paying the lower cost.

Medical deductible does not apply for prescription drugs.

Specialty medications must be filled through CVS Caremark's Specialty Pharmacy; specialty medications are limited to a 30-day fill.

No coordination of benefits applies.

| | In-Network | | Out-of-Network |
|---|---|---|---|
| | **CVS Caremark's Network Retail Pharmacy Copay (30-day supply)** | **CVS Caremark's Network Retail Pharmacy or Mail Order Copay (up to a 90-day supply)** | |
| **Generic Drug (Tier 1)** | $5 copay | $15 copay | Not Covered |
| **Preferred Brand Name Drug (Tier 2)** | $10 copay | $30 copay | Not Covered |
| **Non-Preferred Brand Name Drug (Tier 3)** | $25 copay | $45 copay | Not Covered |
| **Specialty Drug (Tier 4)**[1]<br>Requires a prior authorization | $100 copay | $300[2] copay | Not Covered |
| **Pharmacy Out-of-Pocket Maximum** | $2,000 per individual<br>$4,000 per family | | $4,000 per individual<br>$8,000 per family |
| **Compounded Drugs**<br>(A minimum of one ingredient must be covered through the Plan) | Prescriptions exceeding $300 require prior authorization | | Not Covered |
| **Convalescent or Nursing Home** | Follows the above copay structure | | 50% of the cost of the medication |

[1] The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution

[2] Specialty medications are limited to a 30-day supply. Copay applies only for medications that must be dispensed in 90-day supplies due to packaging

| **Limitations & Exceptions** |
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| 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 CVS Caremark's Mail Service Pharmacy or pay 100% of the cost of the prescription drug. Please call CVS Caremark at (833) 252-6642 or visit www.caremark.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 copay plus the difference in cost between the brand name drug and its generic equivalent unless determined medically necessary through the appeals process. |