MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

Schedule Of Benefits

NON-MARKETPLACE
PLAN F

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, 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.

Local 150 Health Centers – Not subject to deductible		
Operators' Health Centers (OHC), Marathon Health Centers & Midwest Coalition of Labor Health Centers (MCL Health Centers) Services include annual physical exams, preventive care/wellness visits, immunizations, sick visits, chiropractic services, physical therapy, disease/condition management, clinical laboratory services, DOT physicals, specialty services, and more. Patient age requirements and services vary by location. Visit https://local150.org/moe/local-150-health-centers/.	**100%**	
MinuteClinic – Not subject to the deductible		
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.	**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; it does not include coinsurance for orthoptic training or temporomandibular joint disease (TMJ) treatment.	**$4,500 per individual** **$10,000 per family**	**$6,500 per individual, when applicable** **$14,000 per family, when applicable**

Medical Out-of-Pocket Expense Maximum		
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.	**$2,500 per individual** **$6,000 per family**	**$2,500 per individual, when applicable** **$6,000 per family, when applicable**
Medical Benefits – Comprehensive Medical Benefit	**In-Network**	**Out-of-Network**
Annual Maximum Per Plan Year.	**Unlimited**	
Individual Deductible Per person, per Plan Year. All benefits are subject to the deductible unless otherwise noted. 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 to the next Plan Year. In-network and out-of-network deductibles are separate and will not cross apply.	**$100**	**$100, when applicable**
Family Deductible Per Plan Year. Three-month (4th quarter) carryover does not apply.	**$300**	**$300, when applicable**
PPO Networks & Exclusive Partnerships	BlueCross BlueShield PPO, Absolute Solutions, ATI Physical Therapy, Gateway, and 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 one time prior to surgery. Requires approval by the Case Manager.	**80%**	**Not covered**
Emergency Services in a Hospital or Independent Freestanding Emergency Department Facility charges.	**80%**	**80%**
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.	**80%**	**Not covered**
Home Health Care If ordered by a physician. Requires approval by the Case Manager.	**80%**	**Not covered**

Medical Benefits – Comprehensive Medical Benefit	In-Network	Out-of-Network
Outpatient Hospital Services Including licensed surgery centers. Outpatient surgical procedures require approval by the Case Manager unless performed in the doctor's office without anesthesia.	**80%**	**Not covered**
Diagnostic X-rays/Lab X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury.	**80%**	**Not covered**
MRI & CT Scans Services will be covered at 100% and not subject to the deductible if scheduled through Absolute Solutions.	**90%**	**Not covered**
PET Scans Services will be covered at 100% and not subject to the deductible if scheduled through Absolute Solutions.	**100%**	**Not covered**
Outpatient Physical and Occupational Therapy 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.	**80%**	**Not covered**
Outpatient Restorative Speech Therapy (Children and Adults) Must be performed by a licensed provider. Requires approval by the Case Manager.	**50%**	**Not covered**
Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases Must be performed by a licensed provider. Requires approval by the Case Manager.	**50%**	**Not covered**
Orthoptic Training – 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%**	**Not covered**
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.	**80%**	**Not covered**
Preventive Care, including Well Woman and Well Child Care – Not subject to the deductible. Includes routine physical exams, routine labs, routine outpatient visits, routine hearing exams, mammograms, employment physicals, and immunizations.	**100%**	**Not covered**
Chiropractic Services 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.	**80%**	**Not covered**

Medical Benefits – Comprehensive Medical Benefit	In-Network	Out-of-Network
Durable Medical Equipment (DME) – Not subject to the deductible 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.	**80%**	**Not covered**
Foot Orthotics Custom fitted foot orthotics prescribed by a physician. Lifetime maximum: $2,000.	**80%**	**Not covered**
Prosthetic Devices Artificial devices to restore a normal body function. Requires approval by the Case Manager.	**80%**	**Not covered**
Transplants Available to all non-Medicare 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. Private duty nursing maximum: $10,000. Requires approval by the Case Manager.	**80%**	**Not covered**
Transplant Lodging – 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)	
Orthodontic Treatment of Temporomandibular Joint Disease (TMJ) Oral Appliance – 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%**	
Cochlear Implants Requires approval by the Case Manager.	**80%**	**Not covered**
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 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.	**80%**	**Not covered**

Medical Benefits – Comprehensive Medical Benefit	In-Network	Out-of-Network
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%**	**Not covered**
Mental Health and Substance Use	**In-Network**	**Out-of-Network**
Mental Health and Substance Use Network	**Gateway, and Recovery Centers of America (RCA)**	**Not applicable**
Inpatient Care 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.	**Not covered**	**Not covered**
Outpatient Care 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.	**Not covered**	**Not covered**
Residential Facility 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.	**Not covered**	**Not covered**
Member Assistance Program (MAP) 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.	
Death Benefit		
Available to members and eligible dependent(s)	$40,000 per eligible member $2,000 per eligible dependent	
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. 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. For additional information regarding reimbursable and non-reimbursable FSB expenses, please visit 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. 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 the age of 19.	**$2,000 per adult (age 19 and older)**	
Preventative	**100%**	
Basic and Restorative 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.	

This health plan option does not provide benefits for:

- **Behavioral Health/Substance Abuse treatment (unless if received at a Local 150 Health Center, Gateway, or RCA facility)**
- **Accidental Dismemberment**
  - **If the member is in good standing, supplemental Accidental Dismemberment can be purchased through the National Coalition of Labor (visit coalitionoflabor.org for more information).**
- **Short-Term Disability**

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] Requires a prior authorization	$100 copay	$300[2] copay	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 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

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.