RETIREE (PRE-MEDICARE) SCHEDULE OF BENEFITS

Effective January 1, 2022

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 other Plan limitations will not be considered eligible in determining Plan benefits. *Eligible expenses must be medically necessary and are subject to the Calendar 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. **Deductibles and out-of-pocket amounts satisfied under the Active Plan do not carry over to the Midwest Operating Engineers Retiree Welfare Plan (RWP).**

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.

If you have a Medicare eligible dependent not covered by another group health insurance plan, Medicare will be their primary health plan and the RWP (post-Medicare) benefits will be coordinated (reduced) to supplement Medicare's benefits. The eligible dependent must use a provider who participates in Medicare; no benefits will be paid for services provided outside of the Medicare network. **If you have a Medicare eligible dependent of the RWP, please refer to the Retiree (Post-Medicare) Schedule of Benefits posted at www.local150.org/moe/benefits/retirement/retiree-welfare-plan/.**

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

Operators' Health Center (Ages two and up)/Activate Healthcare Clinic (Newborn and up)	
Annual physical exam, preventive care/wellness visits, immunizations, blood draws, condition management, DOT physicals, and physical therapy (available at the Operators' Health Centers only) 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 Out-of-Pocket Expense Maximum	
The amount of money an individual pays toward covered hospital and medical expenses during any one Calendar Year, including the deductible; Does not include premiums, balance-billing charges, Family Supplemental Benefits, dental benefits, prescription drugs and health care not covered by the Plan	$2,500 per individual $6,000 per family

Medical Benefits (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Annual Maximum Per Calendar Year	$2,000,000	

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Medical Benefits (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Individual Deductible Per person, per Calendar Year All benefits are subject to the deductible unless otherwise noted Three-month carryover applies	$300	
Family Deductible Per Calendar Year Three-month carryover does not apply	$700	
PPO Networks	BlueCross BlueShield PPO, Absolute Solutions, ATI	
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	90%	80%
Hospital Emergency Room	90%	80%
Skilled Nursing Facility If recommended by a physician and confinement begins within 30 days of a hospital confinement Maximum per disability: 45 days Requires approval by the Case Manager	90%	80%
Home Health Care If ordered by a physician Including Private Duty Nursing in limited NICU cases Requires approval by the Case Manager	90%	80%
Outpatient Hospital Services Including licensed surgery centers Outpatient surgical procedures require approval by the Case Manager	90%	80%
Diagnostic X-rays/Lab X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury	90%	80%
MRI/CT and PET Scans Deductible does not apply if scheduled through Absolute Solutions	100%	80%
Outpatient Physical and Occupational Therapy Must be performed by a licensed provider Requires approval by the Case Manager	100% and not subject to the deductible if received at an ATI Physical Therapy Facility; otherwise, 90%	80%

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Medical Benefits (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Outpatient Restorative Speech Therapy (Children and Adults) Must be performed by a licensed provider Requires approval by the Case Manager	90%	80%
Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases Individuals age two through five Must be performed by a licensed provider Calendar Year maximum: $2,000 Requires approval by the Case Manager	90%	80%
Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases Individuals age six through age 18 Must be performed by a licensed provider Calendar Year maximum: $500 Requires approval by the Case Manager	90%	80%
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases Individuals through age 18 only (age restriction will not apply if individual satisfies Plan's definition of a handicapped dependent) Must be performed by a licensed provider Requires approval by the Case Manager	100% and not subject to the deductible if received at an ATI Physical Therapy Facility; otherwise, 90%	80%
Orthoptic Training Dependent children up to age 10 only (in lieu of surgery) Training needs to be prescribed by a covered provider Lifetime maximum: 40 visits Not subject to the deductible or out-of-pocket maximums 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	90%	80%
Preventive Care Routine physical exams, immunizations, employment physicals, hearing exams Benefit for member and spouse only Not subject to the deductible Calendar Year maximum: $750	100%	
Well Baby Care Includes routine hospital visits, outpatient visits and immunizations, age limitation of zero to 24 months Not subject to the deductible	100%	
Chiropractic Services Limited to 24 visits per year with a $60 maximum per visit	90%	80%

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Medical Benefits (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
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 Not subject to the deductible or out-of-pocket maximums Electric wheelchair limited to $15,000 Required approval by the Case Manager on equipment over $1,000	80%	
Foot Orthotics Custom fitted foot orthotics prescribed by a physician Calendar Year maximum: $300 Lifetime maximum: $1,500	80%	
Prosthetic Devices Artificial devices to restore a normal body function Requires approval by the Case Manager	80%	
Transplants Available to all non-Medicare members 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	90%	Not covered
Orthodontic Treatment of Temporomandibular Joint Disease (TMJ) Lifetime maximum: $2,500 Not subject to the deductible or out-of-pocket maximums Requires approval by the Case Manager	50%	
Cochlear Implants Requires approval by the Case Manager	90%	Not covered

RETIREE (PRE-MEDICARE) SCHEDULE OFBENEFITS

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Medical Benefits (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
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	90%	
Acupuncture Services performed by a licensed provider within the scope of his or her license Maximum of 12 treatments per Calendar Year Up to $125 allowable per visit	90%	80%
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 of the Case Manager	90%	80%

Mental Illness and Substance Abuse (Subject to the medical deductible)	**In-Network**	**Out-of-Network**
Mental Health and Substance Abuse Network	BlueCross BlueShield PPO	Not applicable
Inpatient Care Requires approval by the Case Manager	90%	80%
Outpatient Care ABA Therapy, IOP and PHP requires approval by the Case Manager	90%	80%
Residential Facility Requires approval by the Case Manager	90%	80%
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 Calendar Year Additional counseling or treatment may require payment	

RETIREE (PRE-MEDICARE) SCHEDULE OF BENEFITS

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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

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

No coordination of benefits applies

Medications used to treat cancer and transplant medications billed by OptumRx are subject to the 4-tier copay structure outlined below.

	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 covered	Not covered
Compounded Drugs (A minimum of one ingredient must be covered through the Plan)	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.

RETIREE (PRE-MEDICARE) SCHEDULE OFBENEFITS

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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	
Calendar Year Maximum No maximum for children under the age of 19	$1,500 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%*	
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.

Family Supplemental Benefit	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.	Maximum per family, per Calendar Year: $1,500