

# OHC PLAN SCHEDULE OF BENEFITS MUNICIPALITY (MONTHLY)

Effective April 1, 2023

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 through the Operators' Health Centers (OHC), Everside Healthcare Clinics, 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 Healthcare Clinics, 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 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).

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<b>Member Eligibility</b>	
<b>Initial Eligibility</b>	The first day of the month in which your employment with your contributing employer begins, and for which your employer makes the required monthly contribution to the Fund on your behalf. If a husband and wife are both Municipal Employees working for the same Municipal Employer, the Municipal Employer shall be required to make monthly contributions to the Fund for family coverage for only one of the spouses, and no monthly contributions are required on the other spouse. The Municipal Employee for whom contributions are not being made will be eligible as a dependent.
<b>Continuing Eligibility</b>	Continuing eligibility will be determined on a month-to-month basis as long as your employer makes the required monthly contribution to the Fund on your behalf. The amount of the required monthly contribution is established by the Trustees and set in the employer's participation agreement with the Trustees. If Municipal Employees are married to each other and work for the same Municipal Employer, the Municipal Employer shall be required to make monthly contributions to the Fund in accordance with Fund policy and negotiated rates with the Municipal Employer.
<b>Self-Payments</b>	Municipal Employees may not make self-payments to the Fund, other than COBRA payments, to continue their eligibility.
<b>Termination of Eligibility</b>	Eligibility will terminate upon the earliest of the following dates: <ul style="list-style-type: none"> <li>• The last day of the month during which your employment terminates;</li> <li>• The last day of the month for which your employer makes the required contribution to the Fund; or</li> <li>• The date of your death.</li> </ul>
<b>Dependent Eligibility</b>	
<b>Initial Eligibility</b>	A dependent who meets the definition of an eligible dependent will become eligible on the date your eligibility is effective or on the date you acquire and enroll the eligible dependent, whichever is later.
<b>Termination of Eligibility</b>	Dependent eligibility will terminate upon the earlier of the following dates: <ul style="list-style-type: none"> <li>• The end of the month in which the dependent stops being an eligible dependent;</li> <li>• The date your coverage terminates, except that in the event of your death, the dependent's eligibility will terminate on the last day of the month for which you had satisfied the continuing eligibility requirements; or</li> <li>• The date of the dependent's death.</li> </ul>

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<b>Operators' Health Center (Ages two and up)/Everside Health Centers (Ages vary at each location)</b>		
Annual physical exam, preventive care/wellness visits, immunizations, blood draws, condition management, DOT physicals, physical therapy (physical therapy is available at both Operators' Health Centers), and behavioral health (available at the Countryside, IL Operators' Health Center via in-person or telehealth; limited behavioral health at the remaining health centers), chiropractor services at Everside Health Centers (Rockford, IL and Davenport, IA) Not subject to the deductible	100%	
<b>CVS Minute Clinics</b>		
<b>Non-Emergency, Unscheduled Acute Illness, or Injuries</b> Additional "cash pay" services are available at a cost to the patient Not subject to the deductible	Most services covered at 100%	
<b>Medical &amp; Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum</b>	<b>In-Network ONLY</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	\$4,500 per individual \$10,000 per family	\$6,500 per individual \$14,000 per family
<b>Medical Benefit (Comprehensive Medical Benefit)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Annual Maximum</b> Per Plan Year	Unlimited	
<b>Individual Deductible</b> 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
<b>Family Deductible</b> 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
<b>Out-of-Pocket Expense Limitation</b> 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
<b>VBP Plan Networks</b>	HST Care Connect, Absolute Solutions, ATI, Gateway, Recovery Centers of America (RCA)	Not applicable

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<b>Medical Benefit (Comprehensive Medical Benefit)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Inpatient Hospital Services</b> 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
<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 HST Care Connect does not contract with Skilled Nursing Facilities Maximum per disability: 45 days	100% of negotiated amount, deductible does not apply	
<b>Home Health Care</b> If ordered by a physician Requires approval by the Case Manager	100%	70% of negotiated amount
<b>Outpatient Hospital Services</b> 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
<b>Emergency Services in a Hospital or Independent Freestanding Emergency Department</b> 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
<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%	70% of negotiated amount
<b>MRI/CT and PET Scans</b>	100% if you use an HST Care Connect provider or schedule through Absolute Solutions	70% of negotiated amount
<b>Outpatient Physical and Occupational Therapy</b> 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
<b>Outpatient Restorative Speech Therapy (Children and Adults)</b> Must be performed by a licensed provider Requires approval by the Case Manager	100%	70% of negotiated amount
<b>Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological Diseases for individuals ages two through 18</b> Must be performed by a licensed provider Requires approval by the Case Manager	100%	70% of negotiated amount

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<b>Medical Benefit (Comprehensive Medical Benefit)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<p><b>Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for individuals through age 18 only</b>            Must be performed by a licensed provider            Requires approval by the Case Manager</p>	100%, if received at an ATI Physical Therapy Facility or when an HST Care Connect provider is used	70% of negotiated amount
<p><b>Orthoptic Training</b>            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</p>	100%	70% of negotiated amount
<p><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            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%</p>	100%	70% of negotiated amount
<p><b>Preventive Care, including Well Woman and Well Child Care</b>            Includes routine physical exams, routine labs, routine outpatient visits and immunizations            Refer to <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> for more information and the list of current ACA-required preventive services</p>	100%	70% of negotiated amount
<p><b>Chiropractic Services</b>            Limit of \$60 per visit and 24 visits per Plan Year            HST Care Connect does not contract with chiropractors</p>	100% of negotiated amount, deductible does not apply	
<p><b>Durable Medical Equipment</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            Requires approval by the Case Manager on equipment over \$1,000</p>	100% of negotiated amount, deductible does not apply	
<p><b>Foot Orthotics</b>            Custom-fitted foot orthotics prescribed by a physician            Plan Year maximum: \$300            Lifetime maximum: \$1,500</p>	100%	70% of negotiated amount
<p><b>Prosthetic Devices</b>            Artificial devices to restore a normal body function            Requires approval by the Case Manager</p>	100%	70% of negotiated amount

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<b>Medical Benefit (Comprehensive Medical Benefit)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<p><b>Transplants</b>            Available to all non-Medicare-eligible 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            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</p>	100%	Not covered
<p><b>Orthodontic Treatment of Temporomandibular Joint Disease (TMJ)</b>            Lifetime maximum: \$2,500            HST Care Connect does not contract with dentists            Requires approval by the Case Manager</p>	100% of negotiated amount, deductible does not apply	
<p><b>Cochlear Implants</b>            Requires approval by the Case Manager</p>	100%	Not covered
<p><b>Medical Transportation</b>            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</p>	100%	100% of the greater of the negotiated amount or the reasonable and customary charge
<p><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            HST Care Connect does not contract with acupuncturists</p>	100% of negotiated amount, deductible does not apply	
<p><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</p>	100% of negotiated amount, deductible does not apply	

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<b>Mental Illness and Substance Abuse (Subject to the medical deductible)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Mental Health and Substance Abuse Network</b>	HST Care Connect, Gateway, RCA	Not applicable
<b>Inpatient Care</b> Requires approval by the Case Manager	100% of negotiated amount, deductible does not apply	
<b>Outpatient Care</b> ABA Therapy, IOP and PHP requires approval by the Case Manager	100% of negotiated amount, deductible does not apply	
<b>Residential Facility</b> Requires approval by the Case Manager	100% of negotiated amount, deductible does not apply	
<b>Member Assistance Program (MAP)</b> 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	
<b>Dental Benefits</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Dental PPO Network and Claims Administration</b>	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
<b>Deductible</b>	\$0	
<b>Plan Year Maximum</b> No maximum for children under age 19	\$1,500 per adult (age 19 and older)	
<b>Preventive</b>	100%	
<b>Basic and Major Services</b> 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	
<b>Orthodontia</b> 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	
<b>Disability Benefit</b>		
Available to members only	\$400 per week for the first 30 days of disability (prorated for any paid days off)	
<b>Death Benefit</b>		
Available to members and eligible dependents	\$40,000 per eligible member \$2,000 per eligible dependent	
<b>Accidental Dismemberment Benefit</b>		
Available to members only	\$1,000 or \$5,000 based on type of loss Limited to \$10,000 for any one accident	

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<b>Family Supplemental Benefit</b>	
<p>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</p> <p>Reimbursement for Plan maximums and items covered at 50% that are not subject to the out-of-pocket maximum are eligible</p> <p>Other than stated above, this benefit cannot be used to reimburse the deductible, copayment, or amount over the reasonable and customary amount</p>	<p>Maximum per family, per Plan Year: \$1,500</p>



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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)	
<b>Generic Drug (Tier 1)</b>	\$5 copayment <sup>(1)</sup> for a 30-day supply	\$15 copayment <sup>(1)</sup> for a 90-day supply	Not covered
<b>Preferred Brand Name Drug (Tier 2)</b>	\$10 copayment <sup>(1)</sup> for a 30-day supply	\$30 copayment <sup>(1)</sup> for a 90-day supply	Not covered
<b>Non-Preferred Brand Name Drug (Tier 3)</b>	\$25 copayment <sup>(1)</sup> for a 30-day supply	\$45 copayment <sup>(1)</sup> for a 90-day supply	Not covered
<b>Specialty Drug (Tier 4)</b> Requires authorization	\$100 copayment <sup>(1)</sup> for a 30-day supply	Not applicable	Not covered
<b>Pharmacy Out-of-Pocket Maximum</b>	\$2,000 per individual \$4,000 per family		\$4,000 per individual \$8,000 per family
<b>Compounded Drugs (A minimum of one ingredient must be covered under the prescription drug program)</b>	Prescriptions exceeding \$300 require authorization		Not covered
<b>Convalescent or Nursing Home</b>	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](http://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/>.*