# RETIREE (PRE-MEDICARE) SCHEDULE OF BENEFITS

Effective January 1, 2024

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

| **Local 150 Primary Medical Homes (Ages vary by location)** | |
|---|---|
| **Operators' Health Centers (OHC), Everside Health Centers & Midwest Coalition of Labor Health Centers (MCL Health Centers)**<br>Annual physical exam, preventive care/wellness visits, immunizations, sick visits, disease/condition management, clinical laboratory services, DOT physicals and specialty services, where available. A full list of services is available at https://local150.org/moe/local-150-primary-medical-homes-2/<br><br>Not subject to deductible | 100% |
| **CVS Minute Clinics** | |
| **Non-emergency, unscheduled acute illness, or injuries**<br>Additional "cash pay" services are available at a cost to the patient<br>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<br>$6,000 per family |

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| Medical Benefits (Comprehensive Medical Benefit) | In-Network | Out-of-Network |
|---|---|---|
| Annual Maximum Per Calendar Year | $2,000,000 | |
| **Individual Deductible**<br>Per person, per Calendar Year<br>All benefits are subject to the deductible unless otherwise noted<br>Three-month carryover applies | $300 | |
| **Family Deductible**<br>Per Calendar Year<br>Three-month carryover does not apply | $700 | |
| **PPO Networks** | BlueCross BlueShield PPO, Absolute Solutions, ATI, Gateway Foundation and Recovery Centers of America (RCA) | |
| **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><br>Requires approval by the Case Manager | 90% | 80% |
| **Hospital Emergency Room** | 90% | 80% |
| **Skilled Nursing Facility**<br>If recommended by a physician and confinement begins within 30 days of a hospital confinement<br>Maximum per disability: 45 days<br>Requires approval by the Case Manager | 90% | 80% |
| **Home Health Care**<br>If ordered by a physician<br>Including Private Duty Nursing in limited NICU cases<br>Requires approval by the Case Manager | 90% | 80% |
| **Outpatient Hospital Services**<br>Including licensed surgery centers<br>Outpatient surgical procedures require approval by the Case Manager | 90% | 80% |
| **Diagnostic X-rays/Lab**<br>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**<br>Deductible does not apply if scheduled through Absolute Solutions | 100% | 80% |
| **Outpatient Physical and Occupational Therapy**<br>Must be performed by a licensed provider<br>Requires approval by the Case Manager | 100% and not subject to the deductible if received at an ATI Physical Therapy Facility; otherwise, 90% | 80% |
| **Outpatient Restorative Speech Therapy (Children and Adults)**<br>Must be performed by a licensed provider<br>Requires approval by the Case Manager | 90% | 80% |

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| Medical Benefits<br>(Comprehensive Medical Benefit) | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases**<br>Individuals aged 2 – 18 years old<br>Must be performed by a licensed provider<br>Requires approval by the Case Manager | 90% | 80% |
| **Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases**<br>Individuals through age 18 only (age restriction will not apply if individual satisfies Plan's definition of a handicapped dependent)<br>Must be performed by a licensed provider<br>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**<br>Dependent children up to age 10 only (in lieu of surgery)<br>Training needs to be prescribed by a covered provider<br>Lifetime maximum: 40 visits<br>Not subject to the deductible or out-of-pocket maximums<br>Requires approval by the Case Manager | 50% | |
| **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 | 90% | 80% |
| **Preventive Care**<br>Routine physical exams, immunizations, employment physicals, routine hearing exams, mammograms<br>Benefit for covered dependents over 24 months<br>Not subject to the deductible | 100% | Not Covered |
| **Preventive Care**<br>Routine physical exams, immunizations, employment physicals, routine hearing exams, mammograms<br>Benefit for member and spouse<br>Not subject to the deductible | 100% | |
| **Well Baby Care**<br>Includes routine hospital visits, outpatient visits and immunizations, age limitation of birth to 24 months<br>Not subject to the deductible | 100% | |
| **Chiropractic Services**<br>Limited to 24 visits per year with a $60 maximum per visit | 100% and not subject to the deductible if received at an Everside Health Center that offers services; otherwise, 90% | 80% |
| **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>Not subject to the deductible or out-of-pocket maximums<br>Electric wheelchair limited to $15,000<br>Required approval by the Case Manager on equipment over $1,000 | 80% | |

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| Medical Benefits (Comprehensive Medical Benefit) | In-Network | Out-of-Network |
|---|---|---|
| **Foot Orthotics**<br>Custom fitted foot orthotics prescribed by a physician<br>Calendar Year maximum: $350<br>Lifetime maximum: $2,000 | 80% | |
| **Prosthetic Devices**<br>Artificial devices to restore a normal body function<br>Requires approval by the Case Manager | 80% | |
| **Transplants**<br>Available to all non-Medicare members<br>Benefit begins five days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure<br>Transportation and lodging maximum: $10,000<br>Private duty nursing maximum: $10,000<br>Requires approval by the Case Manager | 90% | Not covered |
| **Temporomandibular Joint Disease (TMJ) oral appliance**<br>Lifetime maximum: $4,000<br>Not subject to the deductible or out-of-pocket maximums<br>Requires approval by the Case Manager | 50% | |
| **Cochlear Implants**<br>Requires approval by the Case Manager | 90% | 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>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 | 90% | |
| **Acupuncture**<br>Services performed by a licensed provider within the scope of his or her license<br>Maximum of 12 treatments per Calendar<br>Year Up to $125 allowable per visit | 90% | 80% |
| **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 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** | Gateway Foundation, Recovery Centers of America (RCA), and BlueCross BlueShield PPO | Not applicable |
| **Inpatient Care**<br>Requires approval by the Case Manager | 100% and not subject to the deductible if received at Gateway Foundation or RCA; otherwise, 90% | 80% |

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| Mental Illness and Substance Abuse (Subject to the medical deductible) | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient Care**<br>ABA Therapy, IOP and PHP requires approval by the Case Manager | 100% and not subject to the deductible if received at Gateway Foundation or RCA; otherwise, 90% | 80% |
| **Residential Facility**<br>Requires approval by the Case Manager | 100% and not subject to the deductible if received at Gateway Foundation or RCA; otherwise, 90% | 80% |
| **Member Assistance Program (MAP)**<br>Administered by Employee Resource System (ERS) | Provides members and covered dependents with up to five no-cost visits per episode per Calendar Year<br>Additional counseling or treatment may require payment | |
| **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 | |
| **Calendar Year Maximum**<br>No maximum for children under the age of 19 | $2,000 per adult (age 19 and older) | |
| **Preventative** | 100% | |
| **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 | |
| **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.<br>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 Calendar Year:<br>$1,500 | |

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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 prior 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 prior 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.*