

# Health Plan Options Comparison Chart

## Plan Year: January 1, 2026 through December 31, 2026

Retiree Marketplace plans are available exclusively for individuals who are not yet eligible for Medicare (pre-Medicare).



Service Type	Free services are available through the Operators' Health Centers, Marathon Health Centers, MCL Health Centers, ATI Physical Therapy facilities, Absolute Solutions Imaging Network, Gateway Foundation/Recovery Centers of America (RCA), or MinuteClinic's (most services are <u>free</u> ). All services must be deemed medically necessary for consideration.						
	Plan A	EPO	Gold	Bronze			
<b>Local 150 Health Centers</b> (not subject to the deductible) (ages and services vary by location) Operators' Health Centers (OHC), Marathon Health Centers, and Midwest Coalition of Labor Health Centers (MCL Health Centers)							
Primary care for ages 2+, annual school & sports physicals, immunizations, preventive care/wellness visits, behavioral health, chiropractic, and preventive care services, lab services, condition management, DOT physicals, physical therapy, and more.	100%	100%	100%	100%	100%	100%	100%
<b>Family Supplemental Benefit (FSB)</b>							
Per family per Plan Year	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500
	In-Network	Out-of-Network	In-Network ONLY	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Medical Annual Deductible</b> (applies to all services unless noted otherwise)							
Person	\$300	None	None	\$1,000	\$2,000	\$5,000	\$10,000
Family	\$700	None	None	\$2,500	\$5,000	\$10,000	\$20,000
<b>Medical Out-of-Pocket Maximum</b> (applies to all services unless noted otherwise) Balance billing from an out-of-network provider does not apply to your out-of-pocket maximum.							
Person	\$2,500	\$2,500	\$4,000	\$4,000	\$8,000	\$5,000	\$10,000
Family	\$6,000	\$6,000	\$10,000	\$8,000	\$16,000	\$10,000	\$20,000
<b>Hospital Services</b>	90%	80%	Inpatient: \$250 copay/admission Outpatient: \$20 copay/visit	80%	60%	100%	
<b>Emergency Services in a Hospital or Independent Freestanding Emergency Department</b>	90%		\$100 copay/ visit	\$100 copay/visit; balance considered at 80%		\$100 copay/visit; balance considered at 100%	
<b>Preventive Services</b> Not subject to the deductible. *Out-of-network preventive services are covered only for adult physical exams for member, spouse, and well-childcare for children up to age 2.	100%	100%*	100%	100%	100%*	100%	100%*
<b>Physician Visits</b>	90%	80%	Primary: \$20 copay/visit Specialist: \$40 copay/visit	80%	60%	100%	
<b>Chiropractic Services</b> (maximum of \$60 per visit and 24 visits per Plan Year) Services will be covered at 100% and not subject to the deductible if received at a Local 150 Health Center.	90%	80%	\$20 copay/visit	80%	60%	100%	

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	In-Network	Out-of-Network	In-Network ONLY	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Acupuncture</b> (maximum of \$125 per visit and 12 treatments per Plan Year)	90%	80%	\$20 copay/visit	80%	60%	100%	
<b>Outpatient Restorative Speech Therapy</b>	90%	80%	\$20 copay/visit	80%	60%	100%	
<b>Outpatient Speech Therapy for Developmental Conditions including Congenital Neurological Diseases</b>	90%	80%	\$20 copay/visit	80%	60%	100%	
<b>Outpatient Physical and Occupational Therapy</b> Services will be covered at 100% and not subject to the deductible if received at a Local 150 Health Center or ATI Physical Therapy Facility.	90%	80%	\$20 copay/visit	80%	60%	100%	
<b>Lab and X-ray</b>	90%	80%	100%	80%	60%	100%	
<b>Durable Medical Equipment (DME)</b> **Not subject to the deductible or out-of-pocket maximums.	80%**		80%	60%	60%	100%	
<b>Dental Benefit</b>							
<b>Deductible</b>	\$0		\$0	\$0		No benefit	
<b>Plan Year Maximum</b>	Age 19 & older: \$2,000 Under 19: no maximum		Age 19 and older: \$2,000 Under 19: no maximum	Age 19 and older: \$2,000 Under 19: no maximum		No benefit	
<b>Preventive</b>	100%		100%	100%		No benefit	
<b>Basic and Restorative</b> Coinsurance is based on Delta Dental's Allowable Fee. Out-of-Network: You pay costs of services above the Allowable Fee.	70%		70%	70%		No benefit	
<b>Orthodontia</b> (dependent children through age 18)	50%, \$2,000 lifetime maximum		50%, \$2,000 lifetime maximum	50%, \$2,000 lifetime maximum		No benefit	
<b>Prescription Drug Coverage: Copay Structure by Tier</b>							
<b>Short-Term Medication – CVS Caremark Network Retail Pharmacy</b> (Maximum of two 30-day fills, excluding specialty drugs, then must obtain a 90-day supply)							
<b>Generic Drug (Tier 1)</b>	\$5 copay		\$5 copay	\$5 copay		\$20 copay	
<b>Preferred Brand (Tier 2)</b>	\$10 copay		\$10 copay	\$10 copay		\$40 copay	
<b>Non-Preferred Brand (Tier 3)</b>	\$25 copay		\$25 copay	\$25 copay		\$55 copay	
<b>Specialty (Tier 4)<sup>1</sup></b> (requires a prior authorization)	\$100 copay		\$100 copay	\$100 copay		\$100 copay	
<b>Maintenance Medication – CVS, Costco, Kroger Pharmacy &amp; CVS Caremark Mail Service Pharmacy</b> (90-day supply required)							
<b>Generic Drug (Tier 1)</b>	\$15 copay		\$15 copay	\$15 copay		\$50 copay	
<b>Preferred Brand (Tier 2)</b>	\$30 copay		\$30 copay	\$30 copay		\$100 copay	
<b>Non-Preferred Brand (Tier 3)</b>	\$45 copay		\$45 copay	\$45 copay		\$115 copay	
<b>Specialty (Tier 4)<sup>2</sup></b> (requires a prior authorization)	\$300 copay		\$300 copay	\$300 copay		\$300 copay	

<sup>1</sup>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.

<sup>2</sup>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.