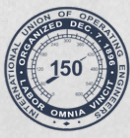


2026
MARKETPLACE COMPARISON CHART

The MOE Health Plan Marketplace has seven different health plans for you to choose from. Please use this chart to review the similarities and differences between the Marketplace plans to determine which plan best for you.

Plans' benefits are subject to eligibility, maximum Plan benefits, reasonable and customary determinations (or negotiated fees for PPO dental services), and any specific limits. Charges that exceed the reasonable and customary amount or other Plan limitations will not be considered 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.

WHAT IS A REASONABLE AND CUSTOMARY CHARGE?

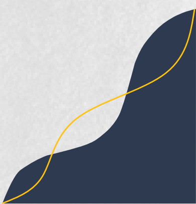
Reasonable and Customary means that the charge, fee, or expense is the smallest of:

- The actual charge for the service
- The provider's usual charge for that service
- Any negotiated rate (if applicable)
- The typical charge for the same service in your area by similar providers

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 Comparison Chart, are applied as of the last day of the month in which the eligible dependent's birthday occurs.

If you have any questions about your health plan options, please contact Member Services at 708-579-6600.



MARKETPLACE HEALTH PLANS COMPARISON CHART

Plan Year Beginning April 1, 2026 through March 31, 2027

Plan Services	Free services are available through the Local 150 Health Centers (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 (There are some cash-pay services). Eligibility requirements apply and primary plan rules must be followed. Only medically necessary services will be considered for coverage.												
	Plan A		**Platinum**		**EPO**	**Gold**		**Operators' Health Center (OHC) Plan**[1]		**Silver**		**Bronze**	
Local 150 Health Centers (not subject to the deductible) (ages vary by location)													
Primary care ages 2+, annual/school physicals, lab services, DOT physicals, physical therapy, chiropractic care, behavioral health services, and more. Services vary by location.	100%		100%		100%	100%		100%		100%		100%	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network ONLY**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Annual Deductible (applies to all services unless noted otherwise)													
Person	$500	$500	$700	$1,400	None	$1,000	$2,000	None	$300	$2,000	$4,000	$5,000	$10,000
Family	$1,100	$1,100	$1,750	$3,500	None	$2,500	$5,000	None	$700	$5,000	$10,000	$10,000	$20,000
Medical Out-of-Pocket Maximum[2] (applies to all services unless noted otherwise)													
Person	$2,500	$2,500	$3,500	$7,000	$4,000	$4,000	$8,000	$2,500	$2,500	$4,000	$8,000	$5,000	$10,000
Family	$6,000	$6,000	$7,000	$14,000	$10,000	$8,000	$16,000	$6,000	$6,000	$8,000	$16,000	$10,000	$20,000
Medical Benefits													
Hospital Services	90%	80%	90%	80%	Inpatient: $250 copay per admission Outpatient: $20 copay per visit	80%	60%	100%	70%	70%	50%	100%	
Preventive Services[3]	100%	100%[4]	100%	No benefit	100%	100%	No benefit	100%	70%	100%	No benefit	100%	No benefit

MARKETPLACE HEALTH PLANS COMPARISON CHART

Plan Year Beginning April 1, 2026 through March 31, 2027

Medical Benefits	Plan A		Platinum		EPO	Gold		Operators' Health Center (OHC) Plan[1]		Silver		Bronze	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY	In- ,Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician Visits	90%	80%	90%	80%	Primary: $20 copay per visit Specialist: $40 copay per visit	80%	60%	100%	70%	70%	50%	100%	
Emergency Services in a Hospital or Independent Freestanding Emergency Department[5]	90%		$100 copay; balance considered at 90%		$100 copay per visit	$100 copay; balance considered at 80%		100%[6]		$100 copay; balance considered at 70%		$100 copay per visit	
Chiropractic Services[7] (maximum of $60 per visit and 24 visits per Plan Year)	90%	80%	90%	80%	$20 copay per visit	80%	60%	100%; HST Care Connect does not currently have network chiropractors. In- and Out-of-Network benefits are covered at 100%		100%		100%	
Acupuncture (maximum of $125 per visit and 12 treatments per Plan Year)	90%	80%	90%	80%	$20 copay per visit	80%	60%	100%; HST Care Connect does not currently have network acupuncturists. In- and Out-of-Network benefits are covered at 100%		70%	50%	100%	
Outpatient Restorative Speech Therapy	90%	80%	90%	80%	$20 copay per visit	80%	60%	100%	70%	70%	50%	100%	
Outpatient Speech Therapy for Developmental Conditions, including Congenital Neurological Diseases	90%	80%	90%	80%	$20 copay per visit	80%	60%	100%	70%	70%	50%	100%	

MARKETPLACE HEALTH PLANS
COMPARISON CHART

Plan Year Beginning April 1, 2026 through March 31, 2027

Medical Benefits	Plan A		Platinum		EPO		Gold		Operators' Health Center (OHC) Plan[1]		Silver		Bronze	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Physical and Occupational Therapy[8]	90%	80%	90%	80%	$20 copay per visit		80%	60%	100%	70%	70%	50%	100%	
Lab and X-ray	90%	80%	90%	80%	100%		80%	60%	100%	70%	70%	50%	100%	
Family Supplemental Benefit (per family per Plan Year)	$2,000		$2,000		$2,000		$2,000		$2,000		$2,000		$2,000	
Dental Benefits														
Deductible	$0		$0		$0		$0		$0		$0		No Benefit	
Calendar-Year Maximum	Age 19 and 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		Age 19 and 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	
Preventive	100%		100%		100%		100%		100%		100%		No Benefit	
Basic and Restorative[9]	70%		70%		70%		70%		70%		70%		No Benefit	
Orthodontia (dependent children through age 18 only)	50% $2,000 lifetime maximum		50% $2,000 lifetime maximum		50% $2,000 lifetime maximum		50% $2,000 lifetime maximum		50% $2,000 lifetime maximum		50% $2,000 lifetime maximum		No Benefit	
Death Benefit														
Member	$40,000		$40,000		$40,000		$40,000		$40,000		$40,000		No Benefit	
Dependent	$2,000		$2,000		$2,000		$2,000		$2,000		$2,000		No Benefit	
Accidental Dismemberment and Disability Benefits														
Accidental Dismemberment	$1,000 OR $5,000 Based on loss $10,000 limit for any one accident												No Benefit	
Disability Benefit	$500 per week for up to 52 weeks Eligibility is credited with 40 hours per week for up to 17 weeks												No Benefit	

MARKETPLACE HEALTH PLANS COMPARISON CHART

Plan Year Beginning April 1, 2026 through March 31, 2027

	Plan A	Platinum	EPO	Gold	Operators' Health Center (OHC) Plan[1]	Silver	Bronze
Prescription Drug Copays							
CVS Caremark Network Retail Pharmacy (Short-term medication - maximum of two 30-day fills, excluding specialty drugs, then must obtain a 90-day supply)							
Generic	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay	$20 copay
Preferred Brand	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$40 copay
Non-Preferred Brand	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay	$55 copay
Specialty[10] (requires a prior authorization)	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay
CVS Caremark Network Retail Pharmacy & the CVS Caremark Mail Service Pharmacy (90-day supply of Maintenance Medication)							
Generic	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay	$50 copay
Preferred Brand	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay	$100 copay
Non-Preferred Brand	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay	$115 copay
Specialty[10] (requires a prior authorization)	$300[11]	$300[11]	$300[11]	$300[11]	$300[11]	$300[11]	$300[11]

	Plan A In-Network	Plan A Out-of-Network	Platinum In-Network	Platinum Out-of-Network	EPO In-Network ONLY	Gold In-Network	Gold Out-of-Network	OHC In-Network	OHC Out-of-Network	Silver In-Network	Silver Out-of-Network	Bronze In-Network	Bronze Out-of-Network
Prescription Out-of-Pocket Maximum													
Person	$2,000	$4,000	$2,000	$4,000	$2,000	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000	$1,600	$4,000
Family	$4,000	$8,000	$4,000	$8,000	$3,200	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000	$3,200	$8,000
Medical and Prescription Combined Out-of-Pocket Maximum													
Person	$4,500	$6,500	$5,500	$11,000	$6,000	$6,000	$12,000	$4,500	$6,500	$6,000	$12,000	$6,600	$14,000
Family	$10,000	$14,000	$11,000	$22,000	$13,200	$12,000	$24,000	$10,000	$14,000	$12,000	$24,000	$13,200	$28,000

[1] In-network services are available at Local 150 Health Centers or HST Care Connect locations (for the OHC Plan). Most out-of-network services will be subject to HST's Value-Based Pricing (VBP). Out-of-network benefits apply when care is received outside a Local 150 Health Center or HST Care Connect.
[2] Balance billing from an out-of-network provider does not apply to your out-of- pocket maximum.
[3] Not subject to deductible. For details on ACA-mandated preventive care services, visit www.healthcare.gov/coverage/preventive-care-benefits/. For details on ACA-mandated preventive care prescription drugs, visit https://local150.org/wp-content/uploads/2025/10/ACA-Preventive-Services-Drug-List_October-2025.pdf. These lists may change periodically.
[4] Out-of-network preventive services are covered only for adult physical exams for member and eligible spouse and well-childcare for children up to age 2.
[5] The No Surprises Act protects patients from unexpected medical bills when receiving emergency care or certain services from out-of-network providers at in-network facilities. It ensures patients are only responsible for in-network cost-sharing amounts and promotes transparency in healthcare pricing. To learn more about your rights and protections under this law, visit http://local150.org/wp-content/uploads/2022/04/NSA-Notice.pdf.
[6] Out-of-Network services are not subject to the deductible if a life-threatening emergency.
[7] Outpatient chiropractic services are covered at 100% for all health plan options if medically necessary and received at a Local 150 Health Center location , not subject to the deductible.
[8] Outpatient physical and occupational therapy is covered at 100% for all health plan options if medically necessary and received at a Local 150 Health Center location or an ATI Physical Therapy facility, not subject to the deductible.
[9] Coinsurance is based on Delta Dental's Allowable Fee. If you use an Out-of-Network provider, you pay the full cost of services above the Allowable Fee.
[10] 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.
[11] 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.