MIDWEST OPERATING ENGINEERS
RETIREE WELFARE PLAN

Pre-Medicare

SCHEDULE OF BENEFITS

Bronze Plan

2026 CALENDAR YEAR

MIDWEST OPERATING ENGINEERS FRINGE BENEFIT FUNDS

This plan is for pre-Medicare individuals only!

A Schedule of Benefits explains what services are covered, the associated costs like copays, deductibles, and coinsurance, and any limitations or exclusions that are included, to give you an idea of what you're going to pay for medical treatments and procedures.

Plans' benefits are subject to eligibility, maximum Plan benefits, reasonable and customary determinations (or negotiated fees for PPO dental 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. To avoid additional out-of-pocket costs, be sure to utilize in-network providers.

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

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)**.

Enrolling in Medicare
You must enroll in both Medicare Part A and Part B when you become entitled by age or entitled early due to a disability. If you do not, the RWP will pay your claims as if you were enrolled in Part A and Part B, leaving you with significantly higher out-of-pocket expenses.

Please note that Retiree Welfare Plan coverage does not include spousal/dependent death benefits, dismemberment benefits, or short-term disability benefits. **This health plan does not include Dental benefits**.

If you have a Medicare eligible dependent who has questions about their covered services or associated costs, please refer to the Retiree Post-Medicare Schedule of Benefits in their My150 library.

Comprehensive Medical Expense Benefits	
Local 150 Health Centers – Not subject to deductible	
Operators' Health Centers (OHC), Marathon Health Centers & Midwest Coalition of Labor Health Centers (MCL Health Centers) Services include annual physical exams, preventive care/wellness visits, immunizations, sick visits, chiropractic services, physical therapy, behavioral health, disease/condition management, clinical laboratory services, DOT physicals, specialty services, and more. Patient age requirements and services vary by location. Visit https://local150.org/moe/local-150-health-centers/.	**100%**
MinuteClinic – Not subject to the deductible	
Located in select CVS and Target locations. Non-emergency, unscheduled acute illness, or injuries. Additional "cash pay" services are available at a cost to the patient.	**Most services covered at 100%**

Medical Out-of-Pocket Expense Maximum		
The most an individual could pay in a Calendar Year for covered services, including the deductible. Individuals covered under Family coverage must meet their own individual out-of-pocket expense limit until the overall Family out-of-pocket expense limit has been met. Does not include premiums, balance-billing charges, Family Supplemental Benefits, TMJ appliance, orthoptic training, prescription drugs, and health care not covered by the Plan. Does not carry over from a pre-Medicare Plan to a post-Medicare Plan.	**$5,000 per individual** **$10,000 per family**	**$10,000 per individual** **$20,000 per family**
Medical Benefits – Comprehensive Medical Benefit	**In-Network**	**Out-of-Network**
Annual Maximum Per Calendar Year.	**$2,000,000**	
Individual Deductible Per person, per Calendar Year. All benefits are subject to the deductible unless otherwise noted. Three-month (4th quarter) carryover applies – Covered Expenses applied against the Individual Deductible in the last three months of a Calendar Year may also be applied to the next Calendar Year. In-network and out-of-network deductibles are separate and will not cross apply. Does not carry over from a pre-Medicare Plan to a post-Medicare Plan.	**$5,000**	**$10,000**
Family Deductible Per Calendar Year. Three-month (4th quarter) carryover does not apply. In-network and out-of-network deductibles are separate and will not cross apply.	**$10,000**	**$20,000**
PPO Networks & Exclusive Partnerships	**BlueCross BlueShield PPO, Absolute Solutions, ATI Physical Therapy, Gateway, and Recovery Centers of America (RCA)**	
Inpatient Hospital Services Room allowances based on the hospital's most common semi-private room rate. Pre-admission testing is covered one time prior to surgery. Requires approval by the Case Manager.	**100%**	
Emergency Services in a Hospital or Independent Freestanding Emergency Department Facility charges.	**$100 copayment per visit**	

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Medical Benefits – Comprehensive Medical Benefit	In-Network	Out-of-Network
Skilled Nursing Facility 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. Maximum per disability: 45 days. Requires approval by the Case Manager.	**100%**	
Home Health Care If ordered by a physician. Including Private Duty Nursing in transplants and limited NICU cases. Requires approval by the Case Manager.	**100%**	
Outpatient Hospital Services Including licensed surgery centers. Outpatient surgical procedures require approval by the Case Manager unless performed in the doctor's office without anesthesia.	**100%**	
Diagnostic X-rays/Lab X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury.	**100%**	
MRI & CT Scans The deductible does not apply when scheduled through Absolute Solutions.	**100%**	
PET Scans – Not subject to the deductible.	**100%**	
Outpatient Physical and Occupational Therapy Must be performed by a licensed provider. Services will be covered at 100% and not subject to the deductible if received at a Local 150 Health Center or an ATI Physical Therapy Facility. Requires approval by the Case Manager. Non-surgical: No authorization is needed for up to 24 visits. Surgical: No authorization is needed for up to 36 visits.	**100%**	
Outpatient Restorative Speech Therapy (Children and Adults) Must be performed by a licensed provider. Requires approval by the Case Manager. Non-surgical: No authorization is needed for up to 24 visits. Surgical: No authorization is needed for up to 36 visits.	**100%**	
Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases, including Congenital Neurological Diseases Must be performed by a licensed provider. Requires approval by the Case Manager. Non-surgical: No authorization is needed for up to 24 visits. Surgical: No authorization is needed for up to 36 visits.	**100%**	

Medical Benefits – Comprehensive Medical Benefit	In-Network	Out-of-Network
Orthoptic Training – Not subject to the deductible or out-of-pocket maximums. Training needs to be prescribed by a covered provider. Does not count toward the medical & prescription drug benefit combined out-of-pocket expense maximum or the medical benefit out-of-pocket expense limitation; if you reach an out-of-pocket maximum, you will continue to pay 50% coinsurance for orthoptic training services; the Plan will not pay 100% for orthoptic training services after you reach a benefit out-of-pocket maximum. 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.	**100%**	
Preventive Care – Not subject to the deductible. Including Well Woman and Well Child Care. Includes routine physical exams, routine labs, routine outpatient visits, routine hearing exams, mammograms, employment physicals, immunizations, and influenza shots.	**100%**	**100% for member and spouse** **100% for well-baby birth to 24 months** **No coverage for children over 24 months**
Chiropractic Services Limited to 24 visits per Calendar Year with a $60 maximum per visit. Services will be covered at 100% and not subject to the deductible if received at a Local 150 Health Center.	**100%**	
Durable Medical Equipment (DME) 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. Power wheelchairs, including accessories, are limited to $15,000. Requires approval by the Case Manager on equipment over $1,500.	**100%**	
Foot Orthotics Custom fitted foot orthotics prescribed by a physician. Lifetime maximum: $2,000.	**100%**	
Prosthetic Devices Artificial devices to restore a normal body function. Requires approval by the Case Manager.	**100%**	

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Medical Benefits – Comprehensive Medical Benefit	In-Network	Out-of-Network
Transplants Available to all non-Medicare members and dependents. *If Medicare is primary, Medicare-eligible members and dependents must use Medicare-approved providers.* Benefit begins five days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure. Private duty nursing maximum: $10,000. Requires approval by the Case Manager.	**100%**	**Not Covered**
Transplant Lodging – Not subject to the deductible. No copayments or coinsurance are applicable. Transportation and lodging maximum: $10,000 within the 18-month transplant period for the initial transplant.	**100%** (network not applicable for this benefit)	
Orthodontic Treatment of Temporomandibular Joint Disease (TMJ) Oral Appliance – Not subject to the deductible or out-of-pocket maximums. Does not count toward the medical & prescription drug benefit combined out-of-pocket expense maximum or the medical benefit out-of-pocket expense limitation. If you reach an out-of-pocket maximum, you will continue to pay 50% coinsurance for TMJ services; the Plan will not pay 100% for TMJ services after you reach a benefit out-of-pocket maximum Lifetime maximum: $4,000. Requires approval by the Case Manager.	**50%**	
Cochlear Implants Requires approval by the Case Manager.	**100%**	**Not Covered**
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.	**100%**	
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.	**100%**	
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 by the Case Manager.	**100%**	

Mental Health and Substance Use – Subject to the deductible	**In-Network**	**Out-of-Network**
Mental Health and Substance Use Network	**BlueCross Blue Shield PPO, Gateway, and Recovery Centers of America (RCA)**	**Not Applicable**
Inpatient Care Services will be covered at 100% and not subject to the deductible if received at a Gateway or RCA facility. Requires approval by the Case Manager.	**100%**	
Outpatient Care Services will be covered at 100% and not subject to the deductible if received at a Gateway or RCA facility. IOP and PHP require approval by the Case Manager.	**100%**	
Residential Facility Services will be covered at 100% and not subject to the deductible if received at a Gateway or RCA facility. Requires approval by the Case Manager.	**100%**	
Member Assistance Program (MAP) Administered by AllOne Health.	Provides members and covered dependents with up to five no-cost visits per episode per Calendar Year. Additional counseling or treatment may require payment.	
Family Supplemental Benefit (FSB)	**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. For additional information regarding reimbursable and non-reimbursable FSB expenses, please visit https://local150.org/moe/family-supplemental-benefit/.	**Maximum per family, per Calendar Year: $1,500**	

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Prescription Drug Coverage

Prescription drug benefits will be paid for prescriptions on the CVS Caremark Formulary when filled at a pharmacy in the CVS Caremark network.

Long-term medications (Maintenance Drugs) must be filled at a CVS retail pharmacy or through the CVS Caremark Mail Service Pharmacy.

Some covered medications may require a Prior Authorization or Step Therapy or may have Quantity Limits. To find out if your medication has any additional requirements or limits, refer to the Commercial Plan Drug List.

Copays listed below are the Plan's basic 4-tier copay schedule; if the cost of the medication is less than the copay listed, you will be responsible for paying the lower cost.

Medical deductible does not apply for prescription drugs.

Specialty medications must be filled through CVS Caremark's Specialty Pharmacy; specialty medications are limited to a 30-day fill.

No coordination of benefits applies.

	In-Network		Out-of-Network
	CVS Caremark's Network Retail Pharmacy Copay (30-day supply)	**CVS Caremark's Network Retail Pharmacy or Mail Order Copay (up to a 90-day supply)**	
Generic Drug (Tier 1)	$20 copay	$50 copay	Not Covered
Preferred Brand Name Drug (Tier 2)	$40 copay	$100 copay	Not Covered
Non-Preferred Brand Name Drug (Tier 3)	$55 copay	$115 copay	Not Covered
Specialty Drug (Tier 4)[1] Requires a Prior Authorization	$100 copay	$300[2] copay	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 copay structure		50% of the cost of the medication

[1] 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.

[2] 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.

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 CVS Caremark's Mail Service Pharmacy or pay 100% of the cost of the prescription drug. Please call CVS Caremark at 833-252-6642 or visit www.caremark.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 copay plus the difference in cost between the brand name drug and its generic equivalent unless determined medically necessary through the appeals process.