MIDWEST OPERATING ENGINEERS
MOE
HEALTH PLAN MARKETPLACE

HEALTH PLAN OPTION COMPARISON CHART—Benefits Effective April 1, 2019 through March 31, 2020

Services Offered	Operators' Health Center[1]		Plan A		Platinum		Gold		Silver		Bronze		EPO
OPERATORS' HEALTH CENTER (not subject to deductible)													
Annual/School Physical Exams, Preventive Care/ Wellness Visits, Immunizations, Blood Draws, Condition Management (Ages two and up)	100%		100%		100%		100%		100%		100%		100%
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
Medical Annual Deductible (applies to all services unless noted otherwise)													
Person	None	$4,000	$300	$300	$500	$1,000	$1,000	$2,000	$2,000	$4,000	$5,000	$10,000	None
Family	None	$10,000	$700	$700	$1,250	$2,500	$2,500	$5,000	$5,000	$10,000	$10,000	$20,000	None
Medical Out of Pocket Maximum (applies to all services unless noted otherwise)													
Person	$2,500	$8,000	$2,500	$2,500	$3,500	$7,000	$4,000	$8,000	$4,000	$8,000	$5,000	$10,000	$4,000
Family	$6,000	$16,000	$6,000	$6,000	$7,000	$14,000	$8,000	$16,000	$8,000	$16,000	$10,000	$20,000	$10,000
Hospital Services	100%	50%	90%	80%	90%	80%	80%	60%	70%	50%	100%		Inpatient: $250 copay per admission Outpatient: $20 copay per visit
Emergency Room (if life-threatening emergency; otherwise, see Hospital Services)	100%*		90%		$100 copay; balance considered at 90%		$100 copay; balance considered at 80%		$100 copay; balance considered at 70%		$100 copay per visit		$100 copay per visit

*Out-of-network services are not subject to the deductible if a life-threatening emergency.

[1] In-Network services are services available through the Operators' Health Clinic (OHC), ATI Physical Therapy facilities, MinuteClinic (CVS/Target retail stores) or Advocate Health System providers (HST Care Connect). 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, ATI Physical Therapy facilities, MinuteClinic (CVS/Target retail stores) or the Advocate Health System.

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
Preventive Services**	100%	Not covered if available at OHC, MinuteClinic or Advocate provider; otherwise covered at 50%	100%	100%***	100%	No benefit	100%	No benefit	100%	No benefit	100%	No benefit	100%
Physicians Visits	100%	50%	90%	80%	90%	80%	80%	60%	70%	50%	100%		Primary: $20 copay per visit Specialist: $40 copay per visit
Chiropractic Services (Maximum of $60 per visit and 24 spinal manipulations per Plan Year)	100%; Advocate does not have network chiropractors at this time, so In- and Out-of-Network benefits are covered at 100%		90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Acupuncture (Maximum of $125 per visit and 12 treatments per Plan Year; MD referral required)	100%; Advocate does not have network acupuncture providers at this time, so In- and Out-of-Network benefits are covered at 100%		90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Outpatient Restorative Speech Therapy	100%	50%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit

**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 www.moefunds.com. These lists may change periodically, and any changes will be effective April 1, 2019.

***For adult physical exams and well child care; no benefit for other ACA-mandated preventive services; covered services may change periodically, and any changes will be effective April 1, 2019.

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
Outpatient Speech Therapy (25 visit limit)	100%	50%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological Diseases for Dependent Children age 2 through age 18 (Limited to 25 visits per Plan Year)	100%	50%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Outpatient Physical and Occupational Therapy****	100%	50%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Outpatient Physical and Occupational Therapy for Congenital Neurological for Dependent Children age 2 through age 18****	100%	50%	90%	80%	90%	80%	80%	60%	70%	50%	100%		$20 copay per visit
Lab and X-ray	100%	50%	90%	80%	90%	80%	80%	60%	70%	50%	100%		100%
Family Supplemental Benefit – per family per Plan Year	$2,000		$2,000		$2,000		$2,000		$2,000		$2,000		$2,000

****Outpatient physical and occupational therapy is covered at 100% for all health plan options if medically necessary and received at an ATI Physical Therapy facility, not subject to the deductible.

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Dental Benefit							
Deductible	$0	$0	$0	$0	$0	No benefit	$0
Calendar Year Maximum	Age 19 and older $1,500. Under 19 no maximum	Age 19 and older $1,500. Under 19 no maximum	Age 19 and older $1,500. Under 19 no maximum	Age 19 and older $1,500. Under 19 no maximum	Age 19 and older $1,500. Under 19 no maximum	No benefit	Age 19 and older $1,500. Under 19 no maximum
Preventive	100%	100%	100%	100%	100%	No benefit	100%
Basic & Restorative	70%	70%	70%	70%	70%	No benefit	70%
Orthodontia	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	50% $2,000 lifetime maximum
Death Benefit							
Member	$40,000	$40,000	$40,000	$40,000	$40,000	No benefit	$40,000
Dependent	$2,000	$2,000	$2,000	$2,000	$2,000	No benefit	$2,000
Accidental Dismemberment and Disability Benefits							
Accidental Dismemberment	$1,000 OR $5,000 Based on loss $10,000 limit for 1 accident					No benefit	$1,000 OR $5,000 Based on loss $10,000 limit for 1 accident
Disability Benefit	$400 per week up to 52 weeks Eligibility is credited with 40 hours/week for up to 17 weeks					No benefit	$400 per week up to 52 weeks Eligibility is credited with 40 hours/week for up to 17 weeks

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Services Offered	Operators' Health Center		Plan A		Platinum		Gold		Silver		Bronze		EPO
Prescription Drug Benefit													
OptumRx Network Retail Pharmacy (Maximum of two 30-day fills, excluding specialty drugs, then required to obtain a 90-day supply.)													
Generic	$5 copay		$5 copay		$5 copay		$5 copay		$5 copay		$20 copay		$5 copay
Preferred Brand	$10 copay		$10 copay		$10 copay		$10 copay		$10 copay		$40 copay		$10 copay
Non-Preferred Brand	$25 copay		$25 copay		$25 copay		$25 copay		$25 copay		$55 copay		$25 copay
Specialty (require prior authorization)	$100 copay		$100 copay		$100 copay		$100 copay		$100 copay		$100 copay		$100 copay
OptumRx Mail Service Pharmacy (90-day supply)													
Generic	$15 copay		$15 copay		$15 copay		$15 copay		$15 copay		$50 copay		$15 copay
Preferred Brand	$30 copay		$30 copay		$30 copay		$30 copay		$30 copay		$100 copay		$30 copay
Non-Preferred Brand	$45 copay		$45 copay		$45 copay		$45 copay		$45 copay		$115 copay		$45 copay
Prescription Out of Pocket Maximum													
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
Person	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000	$1,600	$4,000	$2,000
Family	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000	$3,200	$8,000	$3,200
Combined Out of Pocket Maximum (Includes Both Medical and Prescriptions)													
Person	$4,500	$12,000	$4,500	$6,500	$5,500	$11,000	$6,000	$12,000	$6,000	$12,000	$6,600	$14,000	$6,000
Family	$10,000	$24,000	$10,000	$14,000	$11,000	$22,000	$12,000	$24,000	$12,000	$24,000	$13,200	$28,000	$13,200