PLAN B-1 PPO
SCHEDULE OF BENEFITS
MONTHLY

Effective April 1, 2020

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 Plan Year deductible unless otherwise noted. Age limitations, as specified in this *Schedule of Benefits,* are applied as of the last day of the month in which the eligible dependent's birthday occurs.

Member Eligibility	
Initial Eligibility	The first day of the month following 31 days of employment with a contributing employer.
Continuing Eligibility	Continuing eligibility will be determined on a month-to-month basis as long your employer makes the required contribution to the Fund on your behalf. The amount of the required monthly contribution is established by the Trustees and set in the contributing employer's collective bargaining agreement with the Union.
Self-Payments	Plan B members may make no more than four consecutive monthly self-payments to the Fund. Once those are exhausted, members will be offered COBRA payments.
Termination of Eligibility	Eligibility will terminate upon the earliest of the following dates: • The last day of the month during which your employment terminates; • The last day of the month for which your employer makes the required contribution to the Fund; or • The date of your death.
Dependent Eligibility	
Initial Eligibility	A dependent who meets the definition of an eligible dependent will become eligible on the date your eligibility is effective or on the date you acquire and enroll the eligible dependent, whichever is later.
Termination of Eligibility	Dependent eligibility will terminate upon the earlier of the following dates: • The end of the month in which the dependent stops meeting the definition of an eligible dependent; • The date your coverage terminates, except that in the event of your death, the dependent's eligibility will terminate on the last day of the month for which you had satisfied the continuing eligibility requirements; or • The date of the dependent's death.

"Month" or "monthly" means any of the twelve consecutive months of the year.

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Operators' Health Center	
Annual/School Physical Exams, Preventive Care/ Wellness Visits, Immunizations, Blood Draws, Condition Management Ages two and up Not subject to the deductible	100%

CVS Minute Clinics	
Non-Emergency, Unscheduled Acute Illness or Injuries Additional "cash pay" services are available at a cost to the patient Not subject to the deductible	Most services covered at 100%

Medical & Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum	In-Network *ONLY*	Out-of-Network (Not Covered Except as Noted in Chart)
The amount of money applied toward the medical and pharmacy out-of-pocket maximum; it includes medical deductible and pharmacy copayments; it does not include coinsurance for orthoptic training or temporomandibular joint disease (TMJ) treatment	$4,500 per individual $10,000 per family	$6,500 per individual, when applicable $14,000 per family, when applicable

Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*	Out-of-Network (Not Covered Except as Noted in Chart)
Annual Maximum Per Plan Year	Unlimited	
Individual Deductible Per person, per Plan Year All benefits are subject to the deductible unless otherwise noted The three-month carryover applies	$100	$100, when applicable
Family Deductible Per Plan Year The three-month carryover does not apply	$300	$300, when applicable
Out-of-Pocket Expense Limitation The most an individual could pay in a Plan 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, TMJ, orthoptic training, and health care not covered by the Plan	$2,500 per individual $6,000 per family	$2,500 per individual, when applicable $6,000 per family, when applicable
PPO Network	BlueCross BlueShield (hospital and physicians, MRI and CT scans)	Not applicable

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Inpatient Hospital Services Room allowances based on the hospital's most common semi-private room rate Pre-admission testing is covered once prior to surgery Requires approval by the Case Manager	80%	Not covered
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	80%	Not covered
Home Health Care If ordered by a physician Requires approval by the Case Manager	80%	Not covered
Outpatient Hospital Services Including licensed surgery centers Outpatient surgical procedures not performed in the doctor's office requires approval by the Case Manager	80%	Not covered
Hospital Emergency Room Facility charges	80%	80%
Diagnostic X-rays/Lab X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury	80%	Not covered
Diagnostic MRI/CT and PET Scans	90%	Not covered
Outpatient Physical and Occupational Therapy Must be performed by a licensed provider Requires approval by the Case Manager	100%, not subject to the deductible if received at an ATI Physical Therapy Facility; otherwise 80%	Not covered
Outpatient Restorative Speech Therapy (Children and Adults) Must be performed by a licensed provider Requires approval by the Case Manager	50%	Not covered
Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological Diseases for individuals ages two through 18 Limited to 25 visits per Plan Year Requires approval by the Case Manager Must be performed by a licensed provider Requires approval by the Case Manager	50%	Not covered
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for individuals through age 18 only Must be performed by a licensed provider Requires approval by the Case Manager	100%, not subject to the deductible if received at an ATI Physical Therapy Facility; otherwise 50%	Not covered

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Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*	Out-of-Network (Not Covered Except as Noted in Chart)
Orthoptic Training For dependent children up to age 10 only Training needs to be prescribed by a covered provider Lifetime maximum: 40 visits 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 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%	Not covered
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	80%	Not covered
Preventive Care, including Well Woman and Well Child Care Includes routine physical exams, routine hospital visits, routine outpatient visits and immunizations Refer to **www.moefunds.com** for more information and the list of current ACA-required preventive services	100% subject to ACA guidelines, deductible does not apply	Not covered
Chiropractic Services Limit of $60 per visit and 24 visits per Plan Year	80%	Not covered
Durable Medical Equipment 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 Electric wheelchair limited to $15,000 Not subject to the deductible Requires approval by the Case Manager on equipment over $1,000	80%	Not covered
Foot Orthotics Custom-fitted foot orthotics prescribed by a physician Plan Year maximum: $300 Lifetime maximum: $1,500	80%	Not covered
Prosthetic Devices Artificial devices to restore a normal body function Requires approval by the Case Manager	80%	Not covered

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Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*	Out-of-Network (Not Covered Except as Noted in Chart)
Transplants Available to all non-Medicare-eligible 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 Transportation and lodging maximum: $10,000 Private duty nursing maximum: $10,000 Requires approval by the Case Manager	80%	Not covered
Orthodontic Treatment of Temporomandibular Joint Disease (TMJ) 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: $2,500 Requires approval by the Case Manager	50%	Not covered
Cochlear Implants Individuals age one through 18 Requires approval by the Case Manager	80%	Not covered
Cochlear Implants Individuals age 19 and older Lifetime limit: $30,000 Requires approval by the Case Manager	70%	Not covered
Cancer Drugs Cancer drugs billed by the PBM Drugs billed by the PBM and used to treat cancer are subject to the annual deductible	80% of the prescription charge	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 home hospice care if home is less than 100 miles from hospital Inter-health-care-facility transfer maximum: $5,000	80%	

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Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*	Out-of-Network (Not Covered Except as Noted in Chart)
Acupuncture Services performed by a licensed provider within the scope of his or her license Maximum of 12 treatments per Plan Year Up to $125 allowable per visit	80%	Not covered
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	80%	Not covered

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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, except cancer medication obtained through the PBM

No coordination of benefits applies

Specialty medications must be filled through the Optum Specialty Pharmacy; specialty medications are limited to a 30-day fill

No coverage for out-of-network pharmacies until you reach your out-of-pocket maximum as noted below; once the out-of-pocket maximum is met, prescriptions will be paid at 100%

	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 authorization	$100 copayment(1) for a 30-day supply	Not applicable	Not covered
Pharmacy Out-of-Pocket Maximum	$2,000 per individual $4,000 per family		$4,000 per individual $8,000 per family
Compounded Drugs (A minimum of one ingredient must be covered under the prescription drug program)	Prescriptions exceeding $300 require 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.

For a list of no-cost preventive medications, visit www.moefunds.com/pharmacy.

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Member Assistance Program Benefit	
Member Assistance Program (MAP) Administered by Employee Resource System (ERS)	Provides members and covered dependents with up to five no-cost visits per episode per Plan Year Additional counseling or treatment may require payment

Dental Benefit	In-Network	Out-of-Network
Dental PPO Network and Claims Administration	Delta Dental PPO	Not applicable If you use a non-network dentist, Delta Dental will pay you directly, leaving you responsible to pay the provider
Deductible	$0	
Plan Year Maximum No maximum for children under age 19	$1,500 per adult (age 19 and older)	
Preventive	100%	
Basic and Major Services Fillings, crowns, root canal therapy, oral surgery, dentures, bridgework and other covered dental services	70%*	
Orthodontia Dependent children through age 18 only Lifetime maximum: $2,000 visits	50%*	

*Coinsurance is based on Delta Dental's Allowable Fee. You pay the full cost of services above the Allowable Fee, if you use an Out-of-Network provider.

Death Benefit	
Available to members and eligible dependent	$40,000 per eligible member $2,000 per eligible dependent

Family Supplemental Benefit	
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	Maximum per family, per Plan Year: $1,500

This health plan option does not provide benefits for Disability and Accidental Dismemberment.