



**MARKETPLACE
HEALTH PLAN OPTION COMPARISON CHART—Benefits Effective April 1, 2021 through March 31, 2022**

Services Offered	Under All Plans – Eligible members/dependents can receive FREE services by using the Operators’ Health Centers, ATI Physical Therapy facilities, Absolute Solutions Imaging Network, or MinuteClinic’s (where most services are FREE)												
	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	\$300	\$300	\$300	\$500	\$1,000	\$1,000	\$2,000	\$2,000	\$4,000	\$5,000	\$10,000	None
Family	None	\$700	\$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	\$2,500	\$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	\$6,000	\$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%	70%	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% ²		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



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	Operators’ Health Center ¹		Plan A		Platinum		Gold		Silver		Bronze		EPO
	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 Services³	100%	Not covered if available at OHC or HST Care Connect provider; otherwise covered at 70%	100%	100% ⁴	100%	No benefit	100%	No benefit	100%	No benefit	100%	No benefit	100%
Physician Visits	100%	70%	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 visits per Plan Year)	100%; HST Care Connect 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)	100%; HST Care Connect does not have network acupuncturists 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%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		\$20 copay per visit



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	Operators’ Health Center ¹		Plan A		Platinum		Gold		Silver		Bronze		EPO
	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%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		\$20 copay per visit
Outpatient Speech Therapy for Developmental Conditions, including Congenital Neurological Diseases for Dependent Children Age 2 through Age 18 (limited to 25 visits per Plan Year)	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		\$20 copay per visit
Outpatient Physical and Occupational Therapy⁵	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		\$20 copay per visit
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children Age 2 through Age 18⁵	100%	70%	90%	80%	90%	80%	80%	60%	70%	50%	100%		\$20 copay per visit
Lab and X-ray	100%	70%	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



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	Operators’ Health Center	Plan A	Platinum	Gold	Silver	Bronze	EPO
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 and Restorative⁶	70%	70%	70%	70%	70%	No benefit	70%
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	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 any one accident					No benefit	\$1,000 OR \$5,000 Based on loss \$10,000 limit for any one accident
Disability Benefit	\$400 per week for up to 52 weeks Eligibility is credited with 40 hours per week for up to 17 weeks					No benefit	\$400 per week for up to 52 weeks, eligibility is credited with 40 hours per week for up to 17 weeks



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	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 must obtain a 90-day supply)													
Generic	\$5 copay	\$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	\$10 copay	\$40 copay	\$10 copay					
Non-Preferred Brand	\$25 copay	\$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	\$100 copay					
OptumRx Mail Service Pharmacy (90-day supply)													
Generic	\$15 copay	\$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	\$30 copay	\$100 copay	\$30 copay					
Non-Preferred Brand	\$45 copay	\$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	\$6,500	\$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	\$14,000	\$10,000	\$14,000	\$11,000	\$22,000	\$12,000	\$24,000	\$12,000	\$24,000	\$13,200	\$28,000	\$13,200

1 In-Network services are services available through the Operators’ Health Centers (OHC) or HST Care Connect (network for the OHC Plan). 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 or HST Care Connect.

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

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 www.moefunds.com. These lists may change periodically, and any changes will be effective April 1, 2021.

4 For adult physical exams for member and eligible spouse only; well-childcare for children up to age 2.

5 Outpatient physical and occupational therapy is covered at 100% for all health plan options if medically necessary and received at the Merrillville Operators’ Health Center or an ATI Physical Therapy facility, not subject to the deductible.

6 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.