

Operating Engineers – Local 877

Medical Benefits for Group AB9 Effective 1/1/2019

	NETWORK	NON-NETWORK
Annual Deductible		
Single:	\$250	\$500
Family:	\$500	\$1,000
Annual Out-Of-Pocket Maximum		
Single:	\$2,500	\$2,500
Family*:	\$5,000	\$5,000
Preventive Care		
Routine Physicals (1 per person; per calendar year – age 20+)	100%	85% after deductible
Well Child Care (up to age 20, includes immunizations)	100%	85% after deductible
Routine Mammography (1 annually)	100%	85% after deductible
Routine GYN Exam (1 per person; per calendar year)	100%	85% after deductible
Doctor's Services		
Office Visits – including all charges billed with visit	\$15 copay then 100%	85% R&C* after deductible
Chiropractic Care (maximum 30 visits per person per calendar year)	\$15 copay then 100%	not covered
Speech, Physical & Occupational Therapy (due to illness)	\$15 copay then 100%	85% R&C* after deductible
Physical & Occupational Therapy (due to developmental delay)	not covered	not covered
Chemotherapy & Radiation Therapy	100% after deductible	85% R&C* after deductible
Maternity	100% after deductible	85% R&C* after deductible
Anesthesia	100% after deductible	85% R&C* after deductible
Hospital Services		
Inpatient**	100% after deductible	85% R&C* after deductible
Outpatient	100% after deductible	85% R&C* after deductible
Emergency Room (copay waived if admitted)	\$100 copay then 100%	Paid at In Network Level
Mental Health/Substance Abuse		
Inpatient*	100% after deductible	85% R&C* after deductible
Outpatient	100% deductible waived	85% R&C* after deductible (paid in network with MAP approval)
Other Services		
Skilled Nursing Facility Care/Extended Care Facility (90 days per illness)	100% after deductible	85% R&C* after deductible
Home Health Care (100 visit or 200 hours per calendar year)	100% after deductible	85% R&C* after deductible
Hospice Care	100% deductible waived	85% R&C* after deductible
Prosthetics	100% after deductible	85% R&C* after deductible
Treatment for Temporomandibular Joint Dysfunction (\$750 per person per calendar year)	100% deductible waived	85% R&C* after deductible
Ambulance	100% after deductible	100%
Durable Medical Equipment	100% after deductible	85% R&C* after deductible
Diagnostic Lab, X-Ray & Clinical Tests	100% after deductible	85% R&C* after deductible
Allergy Injections	100% after deductible	85% R&C* after deductible
Infertility Testing	100% after deductible	85% R&C* after deductible
Infertility Treatment	not covered	not covered
Vision Benefit (includes 1 exam, frames, lenses & contacts up to \$300 per person per calendar year)	100% deductible waived	100%
Hearing Benefit 1 exam every 2 years plus \$1,000 an ear for hearing aids every 5 years when services are rendered by a HearUSA, Inc. provider		
Health Club Membership (\$400 per person per calendar year)	100% deductible waived	100%
Alternative/Complementary Benefit (\$500 per person per calendar year) (see Funds Office for eligible benefits)	100% deductible waived	100%
Optum Rx Discount Prescription Drug Benefit		
RX Out-Of-Pocket Maximum	Single: \$3,500	Family: \$7,000
Plan pays 100% after copay		
Retail: 34 day supply	\$7 Generic / \$15 Preferred Brand / \$30 Non Preferred Brand and Specialty	
Mail Order: 34-90 day supply	\$15 Generic / \$30 Preferred Brand / \$60 Non Preferred Brand and Specialty	
Charges for birth control medication and pre-natal vitamins are covered under the prescription plan. Smoking Cessation Medications (prescription only) are covered under the prescription plan.		

*The plan participant is also responsible to pay any amount above the reasonable and customary allowance when services are rendered by an out-of-network provider.

**UTILIZATION REVIEW / HOSPITAL PRE-CERTIFICATION/COMPLEX CASE MANAGEMENT is provided by Care Management Services (CMS). The CMS toll-free number is located on your ID card. If you fail to follow the pre-admission certification requirements, your benefits will be reduced by 15% on otherwise covered charges of a hospital or other facility for each admission.

NOTES: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Plan Document and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern.