OPERATING ENGINEERS HEALTH & WELFARE FUND
BENEFIT PLANS SUMMARY COMPARISON FOR ACTIVES and EARLY RETIREES

	Operating Engineers PPO Plan		**Operating Engineers Kaiser Permanente Plan**	**Operating Engineers Anthem HMO Plan**	**Operating Engineers Health Plan of Nevada** (Nevada Residents Only)
	For Non-PPO Providers	**For PPO Providers**			
Employee Premium	None	None	None	None	None
Explanation of Plans and Options Available to You	If you choose a doctor who is **not** contracted with Anthem Blue Cross the Plan will pay the following benefits according to Plan rules The treatment must be a covered service	If you use Anthem Blue Cross PPO providers, the Plan will pay the following benefits according to Plan rules Treatment must be rendered by a PPO contract provider and be a covered service	If you enroll in this plan you **must** use Kaiser facilities for **all** of your medical care	If you enroll in this plan you **must** choose a participating medical group where you must go for **all** your medical care	If you enroll in this plan, you **must** choose a participating medical group where you must go for **all** your medical care
Deductible	$500 per person per calendar year; maximum $1,500 per family (Applicable to Most Services)	$250 per person per calendar year; maximum $750 per family (Applicable to Most Services)	None	None	None
Annual Out-of-Pocket Maximum | Medical and [1]Pediatric Dental & Vision	Out of Network $6,000 per person; $12,000 per family per calendar year	In-Network $3,000 per person; $6,000 per family per calendar year	$1,500 per person; $3,000 for two or more family members	$1,500 per person; $3,000 for two family members; $4,500 for three or more family members	$6,000 per person; $12,000 per family
Annual Out-of-Pocket Maximum | Rx	Not Applicable	In-Network $3,600 per person; $7,200 per family per calendar year	Not Applicable	Not Applicable	Not Applicable
Calendar Year Maximum	None	None	None	None	None
Pre-Existing Condition Limitations	None	None	None	None	None

1. **Pediatric** services are defined as services for an individual less than 19 years of age.

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	For Non-PPO Providers	**For PPO Providers**			
PROFESSIONAL SERVICES:					
Office Visits	Plan pays a maximum of $15 per visit	Plan pays 90% of the contract rate after a $20 co-pay per visit	$25 co-pay per visit	$25 co-pay per visit	$5 co-pay per visit
Hospital Visits	Plan pays 70% of reasonable and customary charges	Plan pays 90% of the contract rate	$250 co-pay per admission	$250 co-pay per admission	Inpatient - $300 co-pay per admission Outpatient - $200 co-pay per surgery
Lab and X-Ray	Plan pays 70% of reasonable and customary charges	Plan pays 90% of the contract rate	$10 co-pay per service	No charge	Lab - $5 co-pay per service X-ray - $10 co-pay per service
Therapy - Acupuncture, Chiropractic & Physical Therapy (Note: The combined 26 visit limit on the FFS and PPO plans is a combined limit. You do not receive a separate benefit of 26 visits under each plan.)	Plan pays a maximum of $15 per visit with a combined limit of 26 visits per calendar year for Acupuncture and Chiropractic care	Chiropractic - Plan pays 50% of the contract rate Acupuncture and Physical Therapy- Plan pays 90% of the contract rate after a $20 co-pay per visit Acupuncture and Chiropractic care have a combined limit of 26 visits per calendar year	$25 co-pay per visit (See Kaiser's Summary of Benefits for details)	$25 co-pay per visit	$5 co-pay per visit for Physical Therapy and Chiropractic services (see Health Plan of Nevada's Summary of Benefits for details)
Speech Therapy	Plan pays 70% of reasonable and customary charges up to a maximum of $15 per visit	Plan pays 90% of the contract rate	$25 co-pay per visit	$25 co-pay per visit	$5 co-pay per visit
[2]**Preventive Healthcare Services**	Plan covers 70% of reasonable and customary charges	No charge	No charge	No charge	No charge
Surgeon	Plan pays 70% of reasonable and customary charges	Plan pays 90% of the contract rate	No charge	No charge	$100 co-pay per surgery (hospital) $50 co-pay per surgery (surgical facility)
Assistant Surgeon	Plan pays 70% of reasonable and customary charges for second surgeon, assistant surgeon, second assistant surgeon and physician assistant (Only if surgery warrants an Assistant Surgeon)	Plan pays 90% of the contract rate (Only if surgery warrants an Assistant Surgeon)	No charge	No charge	No charge
Anesthetist	Plan pays 70% of reasonable and customary charges	Plan pays 90% of the contract rate	No charge	$35 co-pay per occurrence	$100 co-pay per surgery
Urgent Care Services	Plan pays 70% of reasonable and customary charges	Plan pays 90% of the contract rate	$25 co-pay per visit	$35 co-pay per visit	$20 co-pay per visit

2. **Preventive Services Include**: All preventive services and tests with an A or B rating from the U.S. Preventive Task Force are covered (Additional tests may be covered as required by law)

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	For Non-PPO Providers	**For PPO Providers**			
HOSPITAL SERVICES:					
Inpatient Care – Semi-Private Room and Misc. Charges	Plan pays 70% of reasonable and customary charges	Plan pays 90% of the contract rate	$250 co-pay per admission	$250 co-pay per admission	$300 co-pay per admission
Outpatient Care – Emergency Room Care – Non Emergency	Plan pays a maximum of $15 for Emergency Room visit; 70% of reasonable and customary charges for Lab and X-ray charges	Plan pays 90% of the contract rate	$100 co-pay per visit; waived if admitted	$100 co-pay per visit; waived if admitted	$150 co-pay per visit; waived if admitted
Emergency Room Care – Emergency related	Plan pays 90% of reasonable and customary charges	Plan pays 90% of the contract rate	$100 co-pay per visit; waived if admitted	$100 co-pay per visit; waived if admitted	$150 co-pay per visit; waived if admitted
Ambulatory Surgical Facility	Plan pays 70% of reasonable and customary charges	Plan pays 90% of the contract rate	$250 co-pay per occurrence	$250 co-pay per occurrence	$50 co-pay per surgery
Inpatient Psychiatric Care	Plan pays 70% of reasonable and customary charges (Benefits provided through MHN)	Plan pays 90% of the contract rate (Benefits provided through MHN)	$250 co-pay per admission	$250 co-pay per admission	$300 co-pay per admission
Inpatient Alcohol and Substance Abuse Care	Plan pays 70% of reasonable and customary charges (Benefits provided through MHN)	Plan pays 90% of the contract rate (Benefits provided through MHN)	$250 co-pay per admission for detoxification $100 co-pay per admission for transitional residential recovery services Maximum of 60 days per calendar year, not to exceed 120 days in any 5 year period	$250 co-pay per admission for detoxification only	$300 co-pay per admission
Skilled Nursing Facility	Plan pays 80% of reasonable and customary charges with a 60-day maximum per confinement	Plan pays 90% of the contract rate with a 60-day maximum per confinement	No charge Maximum 100 days per benefit period (2/1 - 1/31)	$250 co-pay per admission Maximum of 100 days per calendar year	$300 co-pay per admission; waived if admitted from an acute care facility Maximum of 100 days per calendar year

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	For Non-PPO Providers	**For PPO Providers**			
OTHER SERVICES:					
Ambulance (medically necessary)	**Emergency Transport**: Plan pays 80% of reasonable and customary charges (Deductible waived) **Non-Emergency Transport**: Plan pays 70% of reasonable and customary charges (Deductible applies) **Transport Between In- Network Hospitals**: Plan pays 100% of reasonable and customary charges (Deductible waived)	**Emergency Transport**: Plan pays 80% of the contract rate (Deductible waived) **Non-Emergency Transport**: Plan pays 80% of the contract rate (Deductible applies) **Transport Between In-Network Hospitals**: Plan pays 100% of the contract rate (Deductible waived)	$50 co-pay per trip	$50 co-pay per trip	$150 co-pay per trip
Hearing Aids	Plan pays 100% to a maximum of $1,000 per ear, once every 3 years	Plan pays 100% to a maximum of $1,000 per ear, once every 3 years	Not covered Note: Coverage available under the Fund's PPO Plan	Not covered Note: Coverage available under the Fund's PPO Plan	$0 co-pay
Durable Medical Equipment	Plan pays 70% of reasonable and customary charges, not to exceed purchase price	Plan pays 90% of the contract rate, not to exceed purchase price	No charge. Including diabetic testing supplies	No charge	$0 co-pay; subject to maximum benefit
Prosthetic Appliances	Plan pays 70% of reasonable and customary charges	Plan pays 90% of the contract rate	No charge	No charge	$750 co-pay per device; subject to maximum benefit

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PRESCRIPTION DRUGS:				
Contract Prescription Card – **Walk-in** (30 Day Supply) **At CVS Caremark Participating Pharmacies**	At participating pharmacies your co-pays are: **$10** for a generic drug **$25** for a preferred brand-name drug **$40** for a non-preferred brand-name drug If there is a generic equivalent for the brand-name drug you choose to purchase, you will pay the co-pay **PLUS 50%** of the difference in price between the brand-name and generic drug **Note:** Maintenance type drugs must be filled in 90-day supplies through the mail order pharmacy or at CVS retail pharmacies (see below)	For generic drugs at Kaiser pharmacies, you pay: **$10** for up to a 31 day supply **$20** for a 100 day supply For brand-name drugs at a Kaiser pharmacy, you pay: **$25** for up to a 31 day supply **$50** for a 100 day supply	At contract pharmacies you pay: **$10** for a generic drug on the Anthem Blue Cross recommended drug list (RDL) For a RDL brand-name drug you pay **$30** For a drug not listed on the RDL you pay **50%** of the drug cost	At contract pharmacies you pay: **$7** for a Tier 1 drug **$30** for a Tier II drug with NO generic equivalent **$50** for a Tier III drug
Contract Prescription Card – **Mail Order** (90 Day Supply) **At the CVS Caremark Mail Order Pharmacy**	At the CVS Caremark Mail Order Pharmacy your co-pays are: **$25** for a generic drug **$62.50** for a preferred brand-name drug **$100** for a non-preferred brand-name drug If there is a generic equivalent to the brand-name drug you choose to purchase, you will pay the co-pay **PLUS 50%** of the difference in price between the brand-name and generic drug	For generic drugs you pay: **$10** for up to a 30 day supply **$20** for a 31-100 day supply	You pay twice the applicable co-pay as outlined above	You pay 2.5 times the applicable co-pay as outlined above
Fee-For-Service Prescription Drug Plan (Non-Participating Pharmacies)	Plan pays 80% of the reasonable and customary charge after satisfaction of the out-of-network calendar year deductible. You may obtain a maximum 60-day supply of any one drug. Once you have obtained a 60-day supply, you must use a CVS Caremark network pharmacy for additional refills. Continued purchases at **non-network** pharmacies will be denied	Not applicable	Not applicable	Not applicable

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	Operating Engineers PPO Plan		Operating Engineers United Concordia Preferred - DPPO	Operating Engineers United Concordia Plus - DHMO	Operating Engineers Delta Dental PMI - DHMO
	For Non-PPO Providers	**For PPO Providers**			
DENTAL/ORTHODONTIA CARE:					
Deductible	$25 per person, per calendar year, $75 per family per calendar year (Combined dental and orthodontia deductible)	$25 per person, per calendar year, $75 per family per calendar year (Combined dental and orthodontia deductible)	In Network $25 per person per calendar year, $75 per family per calendar year Out of Network $100 per person per calendar year, $300 per family per calendar year	No deductible	No deductible
Dental Coverage	Plan pays 100% of the non-contract fee schedule (approximately 50% of charges) Any balance remaining is patient co-pay **Adult Benefit Maximum** 19 years of age and older: $6,200 in any two (2) consecutive year period, per person*	Plan pays 100% of the contract amount **Adult Benefit Maximum** 19 years of age and older: $6,200 in any two (2) consecutive year period, per person*	Plan pays 100% for network dentists Plan pays 50% for non-network dentists **Calendar Year Benefit Maximum** $3,000 per person per calendar year in network, $1,000 per person per calendar year non network	Plan pays 100% of most covered services No maximum Refer to the Plan Schedule of Benefits (available from the Fund Office) for specific coverage and co-pay amounts	No maximum
Orthodontia Coverage	Plan pays 50% of charges up to a lifetime maximum benefit of $3,000* Coverage available to dependent children only	Plan pays 50% of charges up to $3,000* Co-pay is also 50% of charges up to $3,000* Lifetime maximum benefit of $3,000* Coverage available to dependent children only	Plan pays 50% of charges up to lifetime maximum $2,000 lifetime maximum Coverage available to dependent children only	Refer to the Plan Schedule of Benefits (available from the Fund Office) for specific coverage and copay amounts No calendar year maximum Coverage available to dependent children and adults	Refer to the Plan Schedule of Benefits (available from the Fund Office) for specific coverage and copay amounts No Calendar Year maximum Coverage available to dependent children and adults

) Effective with dates of service on or after June 1, 2017

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VISION CARE:				
Eye Examination	Through **Vision Service Plan** (VSP) $15 deductible Exam covered once every 12 months	$25 co-pay per visit	$25 co-pay per visit	Through **Vision Service Plan (VSP)**
Eye Lenses / Frames	Through **Vision Service Plan (VSP)** $25 deductible Lenses covered once every 24 months Frames covered once every 24 months **For the Member Only**: Extra pair of glasses or lenses once every 24 months for a $65 co-pay	Through **Vision Service Plan (VSP)** $25 co-pay Lenses covered once every 24 months Frames covered once every 24 months **For the Member Only**: Extra pair of glasses or lenses once every 24 months for a $65 co-pay	Through **Vision Service Plan (VSP)** $25 co-pay Lenses covered once every 24 months Frames covered once every 24 months **For the Member Only**: Extra pair of glasses or lenses once every 24 months for a $65 co-pay	Through **Vision Service Plan (VSP)** $25 co-pay Lenses covered once every 24 months Frames covered once every 24 months **For the Member Only**: Extra pair of glasses or lenses once every 24 months for a $65 co-pay
SPECIAL NOTES:	**All Plans have limitations and exclusions. Please refer to your Plan Booklet for complete details**	**All Plans have limitations and exclusions. Please refer to your Plan Booklet for complete details**	**All Plans have limitations and exclusions. Please refer to your Plan Booklet for complete details**	**All Plans have limitations and exclusions. Please refer to your Plan Booklet for complete details**