

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

	Operating Engineers PPO Plan		Kaiser Permanente Plan	Anthem HMO Plan	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 ¹Pediatric 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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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 after a \$20 co-pay per visit.	\$25 co-pay per visit.	\$25 co-pay per visit.	\$5 co-pay per visit.
²Preventive 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.

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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PROFESSIONAL SERVICES (cont.):					
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.
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 RoomCare – 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 RoomCare – 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 Carelon Behavioral Health).	Plan pays 90% of the contract rate. (Benefits provided through Carelon Behavioral Health).	\$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 Carelon Behavioral Health).	Plan pays 90% of the contract rate. (Benefits provided through Carelon Behavioral Health).	\$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 100-day maximum per confinement.	Plan pays 90% of the contract rate with a 100-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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OTHER SERVICES:					
Ambulance (medically necessary)	<p>Emergency Transport: Plan pays 80% of reasonable and customary charges (Deductible waived).</p> <p>Non-Emergency Transport: Plan pays 70% of reasonable and customary charges (Deductible applies).</p> <p>Transport Between Out-Of-Network Hospitals: Plan pays 70% of reasonable and customary charges (Deductible applies).</p>	<p>Emergency Transport: Plan pays 80% of the contract rate (Deductible waived).</p> <p>Non-Emergency Transport: Plan pays 80% of the contract rate (Deductible applies).</p> <p>Transport Between In-Network Hospitals: Plan pays 100% of the contract rate (Deductible waived).</p>	\$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.	<p>Not covered.</p> <p>Note: Coverage available under the Fund's PPO Plan.</p>	<p>Not covered.</p> <p>Note: Coverage available under the Fund's PPO Plan.</p>	\$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:					
	<p align="center">Contract Prescription Card</p> <p align="center">Walk-in (30 day supply) at CVS Caremark Network Pharmacies</p>	<p>At participating pharmacies your co-pays are:</p> <p>\$10 for a generic drug. \$25 for a preferred brand-name drug. \$40 for a non-preferred brand-name drug.</p> <p>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.</p> <p>Note: Maintenance type drugs can be filled in 90-day supplies through the CVS Caremark Mail Order pharmacy or at CVS Caremark Network retail pharmacies (see below).</p>	<p>For generic drugs at Kaiser pharmacies, you pay:</p> <p>\$10 for up to a 31-day supply. \$20 for a 100-day supply.</p> <p>For brand-name drugs at a Kaiser pharmacy, you pay:</p> <p>\$25 for up to a 31-day supply. \$50 for a 100-day supply.</p>	<p>At contract pharmacies you pay:</p> <p>\$10 for a generic drug on the Anthem Blue Cross recommended drug list (RDL).</p> <p>For a RDL brand-name drug you pay \$30 for a drug not listed on the RDL you pay 50% of the drug cost.</p>	<p>At contract pharmacies you pay:</p> <p>\$7 for a Tier 1 drug. \$30 for a Tier II drug with NO generic equivalent. \$50 for a Tier III drug.</p>
	<p align="center">Contract Prescription Card</p> <p align="center">Mail-Order (90 day supply) at CVS Caremark Mail Order Pharmacy</p>	<p>At the CVS Mail Order Pharmacy or CVS Caremark Network Retail Pharmacies, your co-pays are:</p> <p>\$25 for a generic drug \$62.50 for a preferred brand-name drug \$100 for a non-preferred brand-name drug</p> <p>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.</p>	<p>For generic drugs you pay:</p> <p>\$10 for up to a 30-day supply. \$20 for a 31–100-day supply.</p>	<p>You pay twice the applicable co-pay as outlined above.</p>	<p>You pay 2.5 times the applicable co-pay as outlined above.</p>
	<p align="center">Fee-for-Service Prescription Drug Plan (Non-Participating Pharmacies)</p>	<p>Plan pays 80% of the reasonable and customary charge after satisfaction of the out-of-network calendar year deductible.</p> <p>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.</p>	<p>Not applicable.</p>	<p>Not applicable.</p>	<p>Not applicable.</p>

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	Operating Engineers PPO Plan		United Concordia Preferred - DPPO	United Concordia Plus DHMO (CA only)	Delta Dental PMI DHMO (CA and NV only)	Western Dental (CA only)
	For Non-PPO Providers	For PPO Providers				
DENTAL/ORTHODONTIA CARE:						
Deductible	\$50 per person, per calendar year,* \$150 per family, per calendar year.* (Combined dental and orthodontia deductible).	\$50 per person, per calendar year,* \$150 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	No deductible
Dental Coverage	Plan pays 100% of the noncontract fee schedule. Any balance remaining is patient co-pay. Adult Benefit Maximum 19 years of age and older: \$3,100 in any calendar year period, per person. *	Plan pays 100% of the contract amount. Adult Benefit Maximum 19 years of age and older: \$3,100 in any calendar 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.	Plan pays 100% of most covered Services. No maximum. Implant coverage available.
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.	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 July 1, 2026

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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.