This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.moefunds.com or by calling 1-708-482-7300.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$300** person/**$700** family; Prescription drugs, durable medical equipment, TMJ, balance billing, excluded services do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$2,500** person/**$6,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Self-payments, balance billing, health care this plan does not cover, amounts reimbursed at 50%, Family Supplement charges, prescription drugs.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes. **$2,000,000**.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, call 1-800-810-2583.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for providers in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-708-482-7300 or visit us at www.moefunds.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-708-482-7300 to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	Yes. You need a referral to see an acupuncture **specialist**.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use in-network providers by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Service You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% co-insurance	20% co-insurance	-- None --
	Specialist visit	10% co-insurance	20% co-insurance	-- None --
	Other practitioner office visit	10% co-insurance for chiropractor (manipulations and necessary x-rays only), acupuncture	20% co-insurance for chiropractor (manipulations and necessary x-rays only), acupuncture	Chiropractor: 24 visits/year up to $60/visit & eligible only if over age 5; Acupuncture: 12 treatments/year up to $125/visit.
	Preventive care/ screening/immunization	No charge	No charge	Member, spouse only: $350 calendar year maximum. No charge for well baby care up to 24 months. Effective April 1, 2017, all services that are authorized to be provided by and at a MinuteClinic, are paid at 100%.

Common Medical Event	Service You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance/test	20% co-insurance/test	-- None --
	Imaging (CT/PET scans, MRIs)	No charge	20% co-insurance/test	-- None --
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com 1-708-482-7300.	Generic drugs	$5 co-pay per 30-day supply retail/$15 co-pay per 90-day supply mail order	Not covered	There is a maximum annual limit of $30,000 on your prescription drug benefit. Maximum of up to two 30-day supplies before a member is required to obtain a 90-day supply. Member seeking third refill must transition to CVS or Target Pharmacy or Caremark Mail Service Pharmacy, or pay 100% of the cost of the prescription drug. You must pay the difference between the cost of a brand and generic plus the brand name co-pay if a generic is available. Certain specialty medications are subject to pre-authorization requirements. Call the phone number listed or visit Caremark's website for more information.
	Brand drugs	$10 co-pay per 30-day supply retail/$30 co-pay per 90-day supply mail order	Not covered	
	Maintenance Drugs (Limited to CVS or Target Pharmacy or Caremark Mail Service Pharmacy Only)	$15 co-pay per 90-day supply generic/$30 co-pay per 90-day supply brand	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	20% co-insurance	Licensed facilities only.
	Physician/surgeon fees	10% co-insurance	20% co-insurance	-- None --
If you need immediate medical attention	Emergency room services	10% co-insurance	20% co-insurance	-- None --
	Emergency medical transporation	10% co-insurance	20% co-insurance	Transfer between inter-health facilities limited to $5,000.
	Urgent Care	10% co-insurance	20% co-insurance	-- None --

Common Medical Event	Service You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	10% co-insurance	20% co-insurance	-- None --
	Emergency medical transporation	10% co-insurance	20% co-insurance	Transfer between inter-health facilities limited to $5,000.
	Urgent Care	10% co-insurance	20% co-insurance	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	20% co-insurance	Room allowances based on semi-private room rate.
	Physician/surgeon fee	10% co-insurance	20% co-insurance	-- None --
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance/office visit, 10% co-insurance other outpatient services	20% co-insurance/office visit, 20% co-insurance other outpatient services	-- None --
	Mental/Behavioral health inpatient services	10% co-insurance	20% co-insurance	-- None --
	Substance use disorder outpatient services	10% co-insurance/office visit, 10% co-insurance other outpatient services	20% co-insurance/office visit, 20% co-insurance other outpatient services	-- None --
	Substance use disorder inpatient services	10% co-insurance	20% co-insurance	-- None --
If you are pregnant	Prenatal and postnatal care	10% co-insurance	20% co-insurance	-- None --
	Delivery and all inpatient services	10% co-insurance	20% co-insurance	-- None --

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost Ifr You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% co-insurance	20% co-insurance	Case manager must approve.
	Rehabilitation services	10% co-insurance	20% co-insurance	Case manager must approve.
	Habilitation services	10% co-insurance	20% co-insurance	Case manager must approve. Calendar year maximum of $2,000 for speech therapy for kids age 2-5 with congenital neurological disorder and calendar year maximum of $500 for kids age 6-18.
	Skilled nursing care	10% co-insurance	20% co-insurance	45-day limit per confinement; must be recommended by physician and begin within 30 days of hospital confinement; not covered if not approved.
	Durable medical equipment	20% co-insurance	20% co-insurance	Case manager approval of amounts over $1,000; $15,000 limit/electric wheelchair.
	Hospice service	10% co-insurance	20% co-insurance	Case manager must approve.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Eye exams and glasses are reimbursable under the Family Supplemental Benefit. You can receive basic vision care at no charge from the Operators' Health Center.
	Glasses	Not covered	Not covered	
	Dental check-up	No charge	No charge	Limited to 2 check-ups per year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery (Except for mastectomy, injuries and to remove scar tissue)
- Hearing aids (Except for cochlear implants)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except transplant patients)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for those services.)**

- Acupuncture ($125 per visit, 12 per year)
- Bariatric surgery (Prior authorization required)
- Chiropractic care (Limited to $60/visit and 24/visits per year) (manipulations and necessary x-rays only)
- Dental care (Adult) ($1,000 annual limit)
- Routine eye care (Eligible for reimbursement from Family Supplemental Benefit)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-708-482-7300. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: (1) Administrative Manager, Midwest Operating Engineers Fringe Benefit Funds, 6150 Joliet Road, Countryside, IL 60525-3994, 1-708-482-7300; or (2) Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-708-482-7300.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,930
- **Patient pays** $1,610

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$600
Co-pays	$10
Co-insurance	$600
Limits or exclusions	$400
Total	**$1,610**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,140
- **Patient pays** $1,260

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Co-pays	$400
Co-insurance	$60
Limits or exclusions	$500
Total	**$1,260**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers,** costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, co-payments,** and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium,** the more you'll pay in out-of-pocket costs, such as **co-payments, deductibles,** and **co-insurance.** You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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