The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see www.moefunds.com or call 1-708-579-6600. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.moefunds.com or call 1-708-579-6600 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical In-network: $100/Individual or $300/family; Medical out-of-network: $100/Individual or $300 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, DME, TMJ and Prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical In-network: $2,500/individual or $6,000/family; Medical Out-of-network: $2,500/individual or $6,000/family; Prescription Drugs (in-network): $2,000 individual or $4,000 family; Prescription Drugs (out-of-network): $4,000 individual or $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, Family Supplemental Benefits, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Call 1-800-810-2583 for a list of medical network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. For acupuncture only.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care/screening/ Immunization	No charge	No charge for Routine physical exams for member and spouse and No charge for well-baby care ages 0 to 24 months. ACA-mandated care is not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No charge for preventive services available at Operators' Health Center. For a list of ACA Preventive Services visit https://www/healthcare.gov/coverage/preventive-care-benefits/.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance/test	30% coinsurance/test	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance/test	30% coinsurance/test	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or 1-708-387-8331	Generic drugs	$5 copay per 30-day supply/retail; $15 copay per 90-day supply (Maintenance Choice)	Not covered	Maximum of up to two 30-day supplies before a member is required to obtain a 90-day supply (Maintenance Choice; either CVS or Target Pharmacy or Caremark Mail Service Pharmacy ONLY). Member seeking third refill must transition to CVS or Target Pharmacy of CVS Caremark Mail Service Pharmacy, or pay 100 % of the cost of the prescription drug. If you choose to take a brand name drug when there is a generic drug available, you must pay the difference between the cost of a brand and generic plus the brand name copay. Certain specialty medications are subject to
	Preferred brand drugs	$10 copay per 30-day supply/retail; $30 copay per 90-day supply (Maintenance Choice)	Not covered	
	Non-preferred brand drugs	$25 copay per 30-day supply/retail; $45 copay per 90-day supply (Maintenance Choice)	Not covered	
	Specialty drugs	$100 copay per 30-day supply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				preauthorization requirements. All specialty prescriptions prescribed prior to April 1, 2017 will remain a $5 copay for generic specialty drugs per 30-day supply and a $10 copay for brand name specialty drugs per 30-day supply. All new specialty prescriptions prescribed on or after April 1, 2017 will be subject to the increased specialty copay tier. Call the phone number listed or visit Caremark's website for more information. For a complete list of ACA-mandated preventive care services (including Prescription medications) visit www.moefunds.com.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Licensed facilities only.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Professional/physician charges may be billed separately and different coinsurance may apply.
	Emergency medical transportation	10% coinsurance	30% coinsurance	Transfer between inter-health facilities limited to $5,000
	Urgent care	10% coinsurance	30% coinsurance	No charge if a CVS Minute Clinic is used.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Room allowances based on semi-private room.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply for in-network preventive services including prenatal care. Depending on the type of services, coinsurance may apply.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Case manager must approve.
	Rehabilitation services	10% coinsurance	30% coinsurance	Case manager must approve.
	Habilitation services	10% coinsurance	30% coinsurance	Case manager must approve. Limited to 25 visits for plan year; speech therapy for kids (age 2-18) with congenital neurological disorder.
	Skilled nursing care	10% coinsurance	30% coinsurance	45 day-limit per confinement; Physician must approve and must begin within 30 days of hospital confinement; not covered if not approved.
	Durable medical equipment	30% coinsurance	30% coinsurance	Case manager approval of amounts over $1,000; $15,000 limit/electric wheelchair.
	Hospice services	10% coinsurance	30% coinsurance	Case manager must approve.
If your child needs dental or eye care	Children's 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 Operator's Health Center.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge	No charge	Coverage limited to two exams per Plan Year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any 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 (except as mandated by the ACA)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture ($125 per visit, 12 per year) • Bariatric surgery (Prior authorization required)	• Chiropractic care (Limited to $60/ visit and 24 visits/ year) (manipulations and necessary x-rays only)	• Dental care (Adult-$600 annual limit; Child-No maximum) • Routine eye care (Eligible for reimbursement from Family Supplemental Benefit)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Administrative Manager, Midwest Operating Engineers Fringe Benefit Funds, 6150 Joliet Road, Countryside, IL 60525-3994, 1-708-482-7300. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance, 320 W. Washington St, 4th Floor, Springfield, IL 6272, www.insurance.illinois.gov/DOI.Director@illinois.gov.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-708-483-7300.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$100**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$20
Coinsurance	$1,160
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,340**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$100**
- **Specialist *[cost sharing]*** **$27**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **30%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$280
Coinsurance	$430
What isn't covered	
Limits or exclusions	$260
The total Joe would pay is	**$1,070**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$100**
- **Specialist *[cost sharing]*** **$29**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$280**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.