



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- <u>network</u> : \$100/Individual or \$300/family; Medical <u>out-of-network</u> : \$100/Individual or \$300/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , <u>DME</u> , <u>TMJ</u> and <u>Prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Medical In- <u>network</u> : \$2,500/individual or \$6,000/family Medical <u>Out-of-network</u> : \$2,500/individual or \$6,000/family; <u>Prescription Drugs (in-network)</u> : \$2,000/individual or \$4,000/ family <u>Prescription Drugs (out-of-network)</u> : \$4,000/individual or \$8,000/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. Call 1-800-810-2583 for a list of medical <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	Yes. For acupuncture only.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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	20% <u>coinsurance</u>	Not covered	<u>Out-of-network</u> services excluded.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	Not covered	<u>Out-of-network</u> services excluded.
	<u>Preventive care/screening/Immunization</u>	No charge-ACA Mandates ONLY	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. No charge for <u>preventive services</u> available at Operators' Health Center. For a list of ACA <u>Preventive Services</u> visit https://www.healthcare.gov/coverage/preventive-care-benefits/ . <u>Out-of-network</u> services excluded.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	<u>Out-of-network</u> services excluded.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	Not covered	<u>Out-of-network</u> services excluded.
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 <u>copay</u> per 30-day supply/retail; \$15 <u>copay</u> 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).
	Preferred brand drugs	\$10 <u>copay</u> per 30-day supply/retail; \$30 <u>copay</u> per 90-day supply (Maintenance Choice)	Not covered	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 <u>prescription drug</u> .
	Non-preferred brand drugs	\$25 <u>copay</u> per 30-day supply/retail; \$45 <u>copay</u> per 90-day supply (Maintenance Choice)	Not covered	If you choose to take a brand name drug when there is a generic available, you must pay the difference between the cost of a brand and

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)	
	<u>Specialty drugs</u>	\$100 <u>copay</u> per 30-day supply	Not covered	<p>generic plus the brand name <u>copay</u>. Certain specialty medications are subject to <u>preauthorization</u> requirements. All specialty prescriptions prescribed prior to April 1, 2017 will remain a \$5 <u>copay</u> for generic specialty drugs per 30-day supply and a \$10 <u>copay</u> for brand name <u>specialty drugs</u> per 30-day supply. All new specialty prescriptions prescribed on or after April 1, 2017 will be subject to the increased specialty <u>copay</u> tier. Call the phone number listed or visit Caremark's website for more information.</p> <p>For a complete list of ACA-mandated preventive care services (including Prescription medications) visit www.moefunds.com.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Licensed facilities only. <u>Out-of-network</u> services excluded.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	<u>Out-of-network</u> services excluded.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Professional/physician charges may be billed separately and different <u>coinsurance</u> may apply.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Transfer between inter-health facilities limited to \$5,000.
	<u>Urgent care</u>	20% <u>coinsurance</u>	Not covered	No charge if a CVS Minute Clinic is used.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	Room allowances based on semi-private room rate. <u>Out-of-network</u> services excluded.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	<u>Out-of-network</u> services excluded.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	20% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply for in-network <u>preventive services</u> including prenatal care. Depending on the type of services, <u>coinsurance</u> may apply. <u>Out-of-network</u> services excluded.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	Case manager must approve. <u>Out-of-Network</u> services excluded.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	Case manager must approve. <u>Out-of-Network</u> services excluded.
	<u>Habilitation services</u>	50% <u>coinsurance</u>	Not covered	Case manager must approve. Limited to 25 visits for <u>plan</u> year; speech therapy for kids (age 2-18) with congenital neurological disorder. <u>Out-of-Network</u> services excluded.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	45 day-limit per confinement; Physician must approve and must begin within 30 days of hospital confinement; not covered if not approved. <u>Out-of-Network</u> services excluded.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Case manager approval of amounts over \$1,000; \$15,000 limit/electric wheelchair. <u>Out-of-Network</u> services excluded.

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)	
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	Case manager must approve. <u>Out-of-Network</u> services excluded.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's glasses	Not covered	Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of this service, even in-network.

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.)

- Behavioral and Mental health services
- Cosmetic surgery (Except for mastectomy, injuries, and to remove scar tissue)
- Dental care (Adult & Child)
- 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 eye care (Adult & Child)
- Routine foot care
- Substance abuse services
- 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)

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]	20%
■ Other [cost sharing]	20%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$20
Coinsurance	\$2,320
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,500

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]	\$55
■ Hospital (facility) [cost sharing]	20%
■ Other [cost sharing]	20%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$280
Coinsurance	\$520
What isn't covered	
Limits or exclusions	\$260
The total Joe would pay is	\$1,160

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$100
■ Specialist [cost sharing]	\$59
■ Hospital (facility) [cost sharing]	20%
■ Other [cost sharing]	20%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$370
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$470