

 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 <u>deductible</u>?	Medical <u>In-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 <u>deductible</u>?	Yes. <u>In-network preventive care</u> , <u>DME</u> , TMJ dental, physical therapy treatment received at an ATI facility, orthoptic training and <u>in-network 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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Medical <u>In-network</u> : \$2,500/individual or \$6,000/family; <u>Prescription Drugs</u> (<u>in-network</u>): \$2,000/individual or \$4,000/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 <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges, Family Supplemental Benefits, TMJ, orthoptic training, dental benefits administered separately by Delta Dental, 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 <u>network provider</u>?	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 <u>referral</u> to see a <u>specialist</u>?	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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	Not covered	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	Not covered	None
	<u>Preventive care/screening/Immunization</u>	No charge. <u>Deductible</u> does not apply.	Not covered	There is also no charge for <u>preventive services</u> available at Operators' Health Center. No charge if a MinuteClinic (CVS/Target retail stores) is used. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	Not covered	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 need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.OptumRX.com/sign-ins.html or 1-855-697-9150.	Generic drugs (Tier 1)	\$5 <u>copay</u> /fill per 30-day supply/retail; \$15 <u>copay</u> /fill per 90-day supply. <u>Deductible</u> does not apply.	Not covered	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 a CVS retail pharmacy or the OptumRx home delivery pharmacy or the member will be required to pay 100% of the cost of the <u>prescription drug</u> .
	Preferred brand drugs (Tier 2)	\$10 <u>copay</u> /fill per 30-day supply/retail; \$30 <u>copay</u> /fill per 90-day supply. <u>Deductible</u> does not apply.	Not covered	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 <u>copay</u> .
	Non-preferred brand drugs (Tier 3)	\$25 <u>copay</u> /fill per 30-day supply/retail; \$45 <u>copay</u> /fill per 90-day supply. <u>Deductible</u> does not apply.	Not covered	No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). Certain specialty medications are subject to <u>preauthorization</u> requirements. Failure to obtain approval will result in the non-payment of benefits.
	<u>Specialty drugs (Tier 4)</u>	\$100 <u>copay</u> /fill per 30-day supply. <u>Deductible</u> does not apply.	Not covered	Your <u>cost sharing</u> for <u>in-network prescription drugs</u> counts toward your <u>prescription drug out-of-pocket limit</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Licensed facilities only. Case manager must approve. Failure to approve may result in the non-payment of benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
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 are covered <u>In-network</u> only.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <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 MinuteClinic (CVS/Target retail stores) is used.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	Room allowances based on semi-private room rate. Case manager must approve. Failure to obtain approval may result in the non-payment of benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	
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 <u>in-network</u> .
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	Prenatal care: No charge. <u>Deductible</u> does not apply.	Not covered	<u>Cost sharing</u> does not apply for <u>in-network preventive services</u> including prenatal care. Depending on the type of services, <u>coinsurance</u> may apply.
		All other visits: 20% <u>coinsurance</u> .		
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	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)	
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. Failure to obtain approval may result in the non-payment of benefits.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not covered	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. No charge and not subject to the <u>deductible</u> if received at an ATI Physical Therapy facility.
	<u>Habilitation services</u>	50% <u>coinsurance</u>	Not covered	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. Limited to 25 visits for <u>plan</u> year; speech therapy for individuals (age 2-18) with congenital neurological disorder.
	<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. Case manager must approve. Failure to obtain approval may result in the non-payment of benefits.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Not covered	Case manager approval of amounts over \$1,000; Failure to obtain approval may result in the non-payment of services; \$15,000 limit/electric wheelchair.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits.
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 Operators' Health Center.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Coverage limited to two exams per <u>Plan</u> Year. Administered separately by Delta Dental.

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)
- 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
- 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 plan year)
- Bariatric surgery (2 per lifetime maximum; prior authorization required)
- Chiropractic care (Limited to \$60/visit and 24 visits/plan year)
- Dental care (Adult-\$1,500 annual limit; Child-No maximum; administered separately by Delta Dental)
- 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 <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist copayment</u>	\$0
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$20
Coinsurance	\$2,320
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist copayment</u>	\$55
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$280
Coinsurance	\$520
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist copayment</u>	\$59
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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:

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

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

Nondiscrimination Notice Under Section 1557 of the Affordable Care Act

Discrimination Is Against the Law

Midwest Operating Engineers Welfare Fund and the Midwest Operating Engineers Retiree Welfare Plan (the “Plans”) comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Each Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Each Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Mr. Thomas M. Bernstein, the Civil Rights Coordinator.

If you believe either Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Mr. Thomas M. Bernstein, Civil Rights Coordinator
Midwest Operating Engineers Fringe Benefit Funds
6150 Joliet Road
Countryside, Illinois 60525-3994
Telephone: 1-708-482-7300
Fax: 1-708-482-3056

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mr. Thomas M. Bernstein is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Illinois/Indiana/Iowa Top Languages

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-708-482-7300.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-708-482-7300.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-708-482-7300。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-708-482-7300. 번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-708-482-7300.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-708-482-7300.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-708-482-7300.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-708-482-7300.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-708-482-7300.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-708-482-7300. पर कॉल करें।
Gujarati	વ્યાજ: જો તમે જરાતી બોલતા હો, તો અમારું ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-708-482-7300.
Urdu	رادرېځ: رگاپا ودر اے تلووب هے، وت پآ وک نابز کی ددم کی تامدخ تقم میں تسدیبا هے۔ لاک رکی 1-708-482-7300.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-708-482-7300.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-708-482-7300.
Arabic	رکذا غللا، نأف تامدخ ءدعاسملا وغللاية رفاوتت كل ناجملا ب. لصتا مقرب 1-708-482-7300 (مقر) . ءظوحلم: اذا تنك ءدحتت
Pennsylvania Dutch	Wann du [Deutsch (Pennsylvania German / Dutch)] schwetszcht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-708-482-7300.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-708-482-7300.まで、お電話にてご連絡ください。
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-708-482-7300.
Lao	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຈະມີຮັບໃຊ້ທ່ານ. ໂທ 1-708-482-7300.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-708-482-7300.
Karen	ymol.ymo;= erh>uwdRAuND AusdmtCd<AerRM>Ausdmtw>rRpXRvXAwwXmbl.vXmphRAeDwrHRb.ohM.vDRIAud; 1-708-482-7300.
Dutch	AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-708-482-7300.
Panjabi	ਧਿਆਨ ਿਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-708-482-7300. 'ਤੇ ਕਾਲ ਕਰੋ।