**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 local150.org/moe/ 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 local150.org/moe/ 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. | 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. In-network preventive care, DME, TMJ dental, covered services received through a direct contract vendor or at a Local 150 Primary Medical Home (Operators' Health Center (OHC), Everside Health Centers & Midwest Coalition of Labor Health Centers (MCL Health Centers)), orthoptic training and in-network 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of- pocket limit for this plan?** | Medical In-network: $2,500/individual or $6,000/family; Prescription Drugs (in- network): $2,000/individual or $4,000/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, TMJ, orthoptic training, dental benefits administered separately through a direct contract preferred dental vendor, 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?** | No. | |

**Effective April 1, 2022,** under the Consolidated Appropriations Act, providers will no longer be able to balance bill members for certain services outlined under the No Surprises Act.
For more information regarding Your Rights and Protections Against Surprise Medical Bills, visit http://local150.org/wp-content/uploads/2022/04/NSA-Notice.pdf.

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% coinsurance | Not covered | None |
| | Specialist visit | 20% coinsurance | Not covered | None |
| | Preventive care/screening/ Immunization | No charge. Deductible does not apply. | Not covered | There is no charge for preventive services received at a Local 150 Primary Medical Home or through a direct contract preferred urgent care vendor.<br><br>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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | Not covered | No charge and not subject to the deductible if medically necessary and received at a direct contract preferred imaging facility. |

| 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 copay/fill per 30-day supply/retail; $15 copay/fill per 90-day supply. Deductible 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 the preferred retail pharmacy or the Pharmacy Benefit Manager's home delivery pharmacy or the member will be required to pay 100% of the cost of the prescription drug.<br><br>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.<br><br>No charge for ACA-required generic preventive drugs such as FDA-approved contraceptives (or brand name drugs if a generic is medically inappropriate).<br><br>Certain specialty medications are subject to preauthorization requirements. Failure to obtain approval will result in the non-payment of benefits.<br><br>Your cost sharing for in-network prescription drugs counts toward your prescription drug out-of-pocket limit. |
| | Preferred brand drugs (Tier 2) | $10 copay/fill per 30-day supply/retail; $30 copay/fill per 90-day supply. Deductible does not apply. | Not covered | |
| | Non-preferred brand drugs (Tier 3) | $25 copay/fill per 30-day supply/retail; $45 copay/fill per 90-day supply. Deductible does not apply. | Not covered | |
| | Specialty drugs (Tier 4) | $100 copay/fill per 30-day supply. Deductible does not apply. | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Not covered | Licensed facilities only. Case manager must approve. Failure to approve may result in the non-payment of benefits. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | Professional/physician charges may be billed separately and are covered in-network only. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Transfer between inter-health facilities limited to $5,000. |
| | Urgent care | 20% coinsurance | Not covered | No charge if received through a direct contract preferred urgent care vendor. |

| 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% coinsurance | Not covered | Room allowances based on semi-private room rate.<br>Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. |
| | Physician/surgeon fees | 20% coinsurance | 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 in-network. **PLEASE NOTE:** No charge and not subject to the deductible if received at a Local 150 Primary Medical Home or a direct contract preferred substance abuse facility. ABA Therapy, IOP, and PHP requires approval by the Case manager. Failure to obtain approval may result in the non-payment of benefits. |
| | Inpatient services | Not covered | Not covered | |
| **If you are pregnant** | Office visits | Prenatal care: No charge. Deductible does not apply.<br>All other visits: 20% coinsurance | Not covered | Cost sharing does not apply for in-network preventive services including prenatal care.<br>Depending on the type of services, coinsurance may apply. |
| | Childbirth/delivery professional services | 20% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 20% coinsurance | 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** | Home health care | 20% coinsurance | Not covered | Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. |
| | Rehabilitation services | 20% coinsurance | 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 deductible if received at a Local 150 Primary Medical Home or a direct contract preferred physical therapy facility. |
| | Habilitation services | 50% coinsurance | Not covered | Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. |
| | Skilled nursing care | 20% coinsurance | Not covered | 45-day limit per confinement; Physician must approve and must begin within 30 days of hospital confinement.<br>Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. |
| | Durable medical equipment | 20% coinsurance. Deductible 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. |
| | Hospice services | 20% coinsurance | 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. |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | No charge. Deductible does not apply. | No charge. Deductible does not apply. | Coverage limited to two exams per Plan Year. Administered separately through a direct contract preferred dental vendor. |

## 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.
- 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)
- Non-routine treatment for flat feet will be covered if approved by the Case Manager and services are medically necessary
- Chiropractic care* (Limited to $60/visit and 24 visits/plan year)
- Private-duty nursing (transplant patients and certain NICU cases)
- Dental care (Adult-$2,000 annual limit; Child-No maximum; administered separately through a direct contract preferred dental vendor)
- 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/healthreform. 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 on how 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 the 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 https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Consumer Services at the information provided at https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/IL.

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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 1-708-482-7300.

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

*No charge if medically necessary and services are received at a Local 150 Primary Medical Home that provides these services.

## 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 copayment** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** | **$12,700** |

**In this example, Peg would pay:**

| Cost Sharing | |
|---|---|
| Deductibles | $100 |
| Prescription Drug Copayments | $10 |
| Coinsurance | $2,210 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,380** |

### 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 copayment** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** | **$5,600** |

**In this example, Joe would pay:**

| Cost Sharing | |
|---|---|
| Deductibles | $100 |
| Prescription Drug Copayments | $350 |
| Coinsurance | $160 |
| *What isn't covered* | |
| Limits or exclusions | $180 |
| **The total Joe would pay is** | **$790** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$100** |
| **Specialist copayment** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** | **$2,800** |

**In this example, Mia would pay:**

| Cost Sharing | |
|---|---|
| Deductibles | $100 |
| Prescription Drug Copayments | $10 |
| Coinsurance | $540 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$650** |

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