To All Participants,

Affordable health care coverage today is a major concern for all of us. As a retired participant in the Midwest Operating Engineers Retiree Welfare Plan, you and your family receive substantial medical benefits. Other benefits, such as dental benefits and the Family Supplemental Benefit, are also available to retired members. The Retiree Welfare Plan is a "retiree-only" plan that is separate from the Active Plan. The Retiree Welfare Plan provides these welfare benefits only to eligible retirees and their eligible dependents.

You are able to enjoy such a high level of benefits because of the cooperative efforts of the Trustees of the Midwest Operating Engineers Retiree Welfare Fund. The Trustees include members of both union and employer groups who participate in the Midwest Operating Engineers Retiree Welfare Plan. The Trustees work toward providing you with the highest quality of welfare coverage and are pleased to give you this description of your benefits.

This book is a Summary Plan Description (SPD) of the Retiree Welfare Plan as of April 1, 2020.

As you receive benefit announcements and updates, note the change in your book and put the announcement in the back pocket of this SPD. *Please keep all of your benefit materials together in a safe place for future reference*. Please share this information with your spouse and/or family, where applicable.

Although this book provides accurate and essential information about the Plan, you should understand that this is not a complete description. If there is ever a conflict between this book and the Plan's legal documents, the Plan's legal documents will prevail. If you have questions about the Retiree Welfare Plan, please contact the Fund Office. Fund Office staff will be happy to help you. You can also visit the Fund's website at **www.moefunds.com.**

Sincerely,
Board of Trustees

My150.com

Visit My150 at www.my150.com to update your profile or address and pay retiree dues. Adult dependents should also have their own login to review their personal information. My150 can be accessed from your computer or tablet. You have 24/7 access to your information anytime, anywhere. You can visit www.my150.com to register and create an account.

The benefits described in this book generally apply to expenses incurred by eligible persons on or after April 1, 2020.

The Trustees reserve the right to change, modify or discontinue all or part of this Plan at any time. The Trustees reserve the right to change the eligibility criteria for retiree benefits under the Plan. You will be notified of any changes and all changes would be subject to the Plan's provisions and applicable laws.

For more information regarding the Retiree Welfare Plan and your benefits, visit the Midwest Operating Engineers Fringe Benefit Funds' website at **www.moefunds.com.**

Este folleto contiene un sumario en Ingles de sus derechos y beneficios bajo el Plan. Si tiene dificultad en entender cualquier parte de este folleto póngase en contacto con el Midwest Operating Engineers Fringe Benefit Funds, 6150 Joliet Road, Countryside, IL 60525-3994. Las horas de oficina son de 8:00 a.m. a 5:00 p.m., de Lunes a Viernes. Para obtener asistencia también puede llamar a las oficinas al 1-708-482-7300.

MIDWEST OPERATING ENGINEERS RETIREE WELFARE FUND

6150 Joliet Road
Countryside, Illinois 60525
708-482-7300

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Thompson Coburn LLP

IMPORTANT CONTACT INFORMATION

Service providers are subject to change. The information in this chart is effective April 1, 2020.

Call	For	Phone Number	Website
Fund Office	**General Information**	708-482-7300 800-323-3060	**www.moefunds.com**
	Member Services Medical claims General Welfare Fund benefits Active eligibility	708-579-6600	
	COBRA Eligibility Applications Payment information	708-579-6635	
	Retirement Services Group Pension	708-579-6630	
	Applications, Transferring Credits Working in Retirement RWP Eligibility and Self-Payments	708-937-0327	
	Retiree Member Advocate	708-937-1731	
	Member Advocate	708-579-6672	
	Pharmacy Benefit Department	708-387-8331	
ATI Physical Therapy	Physical and occupational therapy treatment providers	833-284-0001	**ATIpt.com/MOE**
BlueCross BlueShield of Illinois	Finding a PPO hospital or doctor Finding MRI, PET or CT scan providers and scheduling appointments	800-810-2583	**www.bcbsil.com**
Blue Card (through BlueCross BlueShield of Illinois)	Finding a PPO hospital or doctor outside of Illinois	800-810-2583	**www.bcbsil.com**
OptumRx	Prescription drug benefit and mail order information	855-697-9150	**www.optumrx.com**
Delta Dental of Illinois	Finding network dental providers Dental claims	800-323-1743	**www.deltadentalil.com**
Employee Resource System (ERS)	Members Assistance Program (MAP) Finding mental health/substance abuse treatment and providers in the BlueCross BlueShield network	855-374-1674	**www.ers-eap.com**
EyeMed	Discounted vision services and supplies Vision Claims	866-393-3401	**www.eyemed.com**
Valenz Care	Transplants, case management/ certification information and resources to find mental health and substance abuse treatment providers	855-298-0493	**www.valenzhealth.com**
MinuteClinic	Finding a MinuteClinic	866-389-2727	**www.minuteclinic.com**
Operators' Health Centers (OHC)	Routine primary care, acute/urgent care, clinical laboratory services, disease/condition management, and patient education	Countryside, IL: 708-485-2273 Merrillville, IN: 219-525-1150	**www.moefunds.com** **www.operatorshealthcenter.com**
Operators' Health Center Patient Portal	Schedule appointments, send secure messages to your provider, check lab results		**www.mypremisehealth.com**

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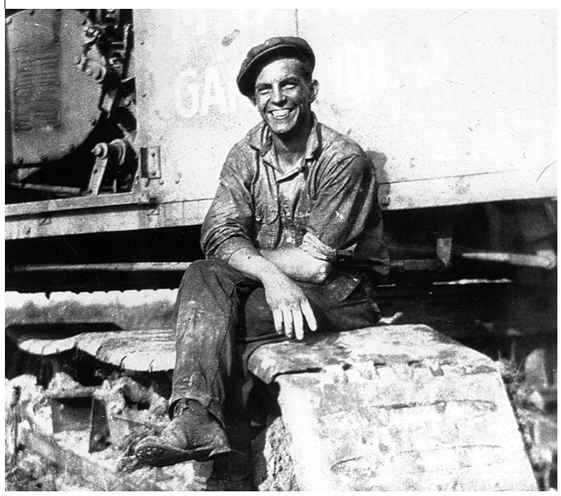


BENEFIT OVERVIEW

The coverage provided by the Plan for you and your eligible dependents is one of your most valuable assets, especially in view of today's rising health care costs.

YOUR BENEFITS

Your coverage includes these major features. For more details, see the complete description in each section.

Comprehensive Medical Coverage	**Retired Participants Without Medicare** The Plan's comprehensive medical coverage covers most medical expenses up to $2 million per calendar year. Some of the benefits are not subject to a deductible or copayment, which means they are paid at 100%, with no cost to you. Others have a $300 per person, per calendar year deductible (with a $700 family deductible maximum). The deductible amounts cross apply for in-network and out-of-network expenses. You pay less when you use an in-network PPO provider and more when you use an out-of-network provider. You receive higher benefit coverage when you go to a medical provider associated with the medical PPO network. This network consists of doctors and hospitals that offer discounts on quality services for our covered eligible retirees and dependents. For more information about PPO providers, go to page 17. See *Eligible Medical Expenses* starting on page 20 for a description of the type of medical expenses covered by the Plan. **Retired Participants With Medicare** If and when you become eligible for Medicare, you must enroll in Part A and Part B. Medicare will become your primary plan for all medical expenses except prescription drugs. This Plan will coordinate with Medicare to supplement those benefits.
Operators' Health Center Benefit	You can receive routine primary care, allergy management, acute/urgent care and other outpatient care free of charge. The OHC is for eligible retirees and eligible dependents ages two and up. See page 27.
Prescription Drug Benefit	Prescription drug benefits are described on pages 28 to 32.
Dental Benefit	Dental benefits are described beginning on page 33.
Family Supplemental Benefit	You can receive up to $1,500 per calendar year for your family's medically necessary non-covered health care expenses as described on page 38.

ELIGIBILITY FOR COVERAGE

WHO IS ELIGIBLE

Retiree Welfare Plan benefits are provided to eligible retirees and elected eligible dependents. As a retiree, you will be eligible for Retiree Welfare Plan benefits if you meet ALL of the following requirements:

- You have reached Early Retirement Age (as defined in the Midwest Operating Engineers Pension Plan) and retired from covered active employment. The age requirement will be waived for members that retire on a Disability Pension;
- Your are receiving a Normal Retirement Pension, Early Retirement Pension, or Disability Pension under the Midwest Operating Engineers Pension Plan;
- You have at least ten Vesting Service Years under the Midwest Operating Engineers Pension Plan. This requirement will be waived for involuntary termination of Staff Employees; this does not apply to Staff Employees that were terminated due to cause;
- Effective January 1, 2019, you are or become a member in good standing of the International Union of Operating Engineers Local 150, and any other union whose collective bargaining agreement requires contributions to the Fund. This requirement does not apply to Retirees who retired prior to January 1, 2019;
- Effective April 1, 2019:
  - You must have 120 consecutive months of eligibility or continuous eligibility since April 1, 2016, whichever is less, under the Active Plan; and
  - Through March 31, 2024, you must have worked at least 800 hours for which contributions were required to be made in each the five Active Plan Years immediately preceding the Active Plan Year containing the Effective Date of retirement, or have worked a total of 5,000 hours for which contributions were required to be made during the same five Active Plan Years and remained on the out-of-work list and have been actively seeking and available for work.
  - If you are determined to be continuously disabled at any point during the five Active Plan Years immediately preceding the Active Plan Year containing the Effective Date of retirement, then you will be considered to have worked 40 hours per week during the period of continuous disability.
  - If you are caring and primarily responsible for a seriously ill parent, child, or spouse, then you will be considered to have worked 40 hours per week during the period of care for this family member. If you are called to active military duty, then you will be allocated 40 hours per week during periods of military service. These hours will only be considered towards the 800-hour or 5,000 hour requirements.
- If you are awaiting the outcome of a Worker's Compensation Disability decision, you must retire no later than 36 months from the last active contribution or 12 months from the date of settlement, whichever occurs first.

MUNICIPALITY EMPLOYEES

If you are a Municipality Employee, you are eligible for retiree benefits if you were a member of the bargaining unit represented by Local 150 on the effective date of the initial collective bargaining agreement between Local 150 and the municipality. The municipality on the effective date of the initial collective bargaining agreement must have provided retiree health benefits which were paid in whole or in part by that employer.

As a retiree, you will be eligible for Retiree Welfare Plan benefits if you meet ALL of the following requirements:

- You have reached retirement age of 50 and retired from covered active employment;
- Other than Valley View Employees, you are receiving pension benefits including a Total and Permanent or Temporary Disability Pension under the Illinois Municipality Retirement Fund (IMRF) or the Indiana Public Retirement System (INPRS) aka Public Employees' Retirement Fund (PERF) or were entitled to receive such a pension benefit but instead elected to receive a lump sum distribution;
- You have accumulated at least ten Vesting Service Years under the IMRF or the (INPRS) Fund PERF as of his effective date of retirement;

- For Municipality groups that were certified with the Union prior to January 1, 2011: You have less than 10 years in the Active Plan, you may be granted the minimum eligibility requirement of ten years, provided you were a member of the bargaining unit represented by the Union on the effective date of the initial collective bargaining agreement between the Union and the Municipality; and
- Effective on or after January 1, 2019, you are or become a member in good standing with any other union whose collective bargaining agreement requires contributions to the Fund. This requirement does not apply to Retirees who retired prior to January 1, 2019.
- If you are awaiting the outcome of a Worker's Compensation Disability decision, you must retire no later than 36 months from the last active contribution or 12 months from the date of settlement, whichever occurs first.

Important! Municipality groups that join the Plan on or after July 16, 2019, are not eligible to contribute to the Plan to provide subsidized coverage. Eligible retirees of new Municipality groups must self-pay for retiree benefits for themselves and their eligible dependents, subject to the self-payment requirements under the Plan.

LANDSCAPERS (PLAN E-1 PPO)

As a retiree who previously worked under the Landscape Contractors Labor Agreement, you will be eligible for Retiree Welfare Plan benefits if you meet ALL of the following requirements:

- You reached Early Retirement Age (as defined in the Midwest Operating Engineers Pension Plan) from covered active employment;
- You were covered as an active employee for at least 12 consecutive months under the Active Plan prior to January 1, 1998;
- You were eligible under the Railroad Maintenance and Industrial Health and Welfare Fund during the 12 consecutive months immediately prior to retirement;
- You were covered as an active employee under the Active Plan or the Railroad Maintenance and Industrial Health and Welfare Fund for at least ten years;
- You accumulated at least ten years of credited service under the Midwest Operating Engineers Pension Plan; and
- You are receiving a Normal Retirement Pension, Early Retirement Pension, or Disability Pension under the Midwest Operating Engineers Pension Plan.
- Any period of coverage under the Railroad Maintenance and Industrial Health and Welfare Fund shall not be counted as a period of coverage under the Active Plan for the purpose of determining the amount the Retiree is required to self-pay for Retiree Benefits under this Plan.
- Effective January 1, 2019, you are or become a member in good standing of the International Union of Operating Engineers Local 150, and any other union whose collective bargaining agreement requires contributions to the Fund. This requirement does not apply to Retirees who retired prior to January 1, 2019; and
- If you are awaiting the outcome of a Worker's Compensation Disability decision, you must retire no later than 36 months from the last active contribution or 12 months from the date of settlement, whichever occurs first.

TRUSTEES

The Trustees of any of the following are eligible for Retiree Welfare Plan benefits:

- The Midwest Operating Engineers Pension Fund;
- The Midwest Operating Engineers Welfare Fund;
- The Midwest Operating Engineers Retiree Welfare Plan;
- The Operating Engineers Local 150 Retiree Welfare Plan;
- The Local 150, I.U.O.E. Vacation Savings Plan, prior to December 31, 2017;
- The Midwest Operating Engineers Retirement Enhancement Fund;
- The Midwest Operating Engineers Construction Industry Research Service Trust Fund; and
- The Midwest Operating Engineers Information Technology Services Corporation.

STAFF EMPLOYEES

A person employed by and under the direction and control of any of the following:

- The Union;
- An association;
- The Trustees of the Midwest Operating Engineers Pension Fund;
- The Trustees of the Midwest Operating Engineers Welfare Fund;
- The Trustees of the Midwest Operating Engineers Retiree Welfare Fund;
- The Trustees of the Operating Engineers Local 150 Apprenticeship Fund;
- The Trustees of the Midwest Operating Engineers Construction Industry Research Service Trust Fund; or
- The Midwest Operating Engineers Information Technology Services Corporation.

On whose behalf such employer is obligated to make contributions to the Fund.

APPLYING FOR RETIREE WELFARE PLAN BENEFITS

It is very important that you apply for and choose Retiree Welfare Plan benefits coverage before you retire.

You may elect to cover only yourself, or you may elect to cover yourself and your eligible dependents. Upon application for Retiree Welfare Plan benefits, a Retiree must elect coverage for himself and any current dependents.

In the event of the death of your eligible dependent, the change to your coverage will be effective no later than the first day of the calendar month beginning after the date the required documents for disenrollment are received by the Plan. The deceased eligible dependent's coverage will end on the date of death.

DECLINING COVERAGE FOR ELIGIBLE DEPENDENTS

At the time of your retirement, you may defer coverage one-time only for your eligible dependents if they are enrolled in other coverage at the time. Coverage may only be declined and late enrollment is only allowable if the dependents are covered under another group health plan, health insurance, or state Medicaid or CHIP program. You may later enroll them in the Plan upon a loss of coverage, unless that other coverage terminates for fraud or failure to make the required payments, including COBRA. **If coverage is deferred due to the availability of other coverage, and there is a subsequent loss of access to that coverage, enrollment for coverage under the Plan must be made within 60 days.** The failure to enroll eligible dependents in coverage upon retirement or to properly defer coverage for eligible dependents due to other coverage at retirement will result in the inability to enroll eligible dependents in coverage at a later date unless the individual qualifies as a newly eligible dependent.

COVERAGE DUE TO A LIFE CHANGING EVENT

You must provide all required documentation within 6 months.

- The Plan will provide at least 6 months for you or your dependents to request coverage after the occurrence of these events.
- If the event was a marriage, the coverage will be effective no later than the first day of the first calendar month beginning after the date the completed enrollment document is received by the Plan.
- If the event was a divorce, your coverage change will be effective no later than the first day of the calendar month beginning after the date the completed documents for disenrollment are received by the Plan. Your ex-spouse's coverage ends at the end of the month during which the date of the divorce occurred.
- In the case of birth, adoption or placement for adoption, as long as you provide required documents within the 6-month period, coverage will be effective no later than the date of the event.
- If coverage is deferred due to the availability of other coverage, and there is a subsequent loss of access to that coverage, enrollment for coverage under the Plan must be made within 60 days.
- **If you or your dependent does not request coverage within the 6-month period, you or your dependent will lose the right to elect coverage and will not be enrolled in the Plan.**

PAYING FOR RETIREE WELFARE PLAN BENEFITS

You must make self-payments for Retiree Welfare Plan benefits. The amount of the self-payment is determined by the Trustees in their sole discretion and may be changed at any time.

Payments are due to the Fund by the 15th day of the prior month; however, the Plan provides a 30-day grace period.

RUNNING OUT YOUR CREDIT BANK

Before your retiree self-payments start, you must run out any remaining credit in your Credit Bank to pay for Active Plan coverage. Once your Credit Bank depletes, the remainder of the credits will be used to pay the lesser of the active self-payment rate or the retiree self-payment rate. All subsequent self-payments shall be the Retiree self-payment amount.

RETIREE MEDICAL SAVINGS PLAN (RMSP)

When you retire, if you are eligible for the Midwest Operating Engineers retiree health care coverage, you can use the funds in your Retiree Medical Savings Plan (RMSP) account to cover your retiree self-payment premiums. In addition, your RMSP account can be used to pay for your and your eligible dependent's Medicare premiums, tax-qualified long-term care insurance premiums or tax-qualified nursing care expenses. See pages 40 and 41 for more information about the RMSP program.

IF YOU RETURN TO WORK

After you become eligible as a retiree you are allowed to return to work as an active employee one time only without affecting your eligibility for Retiree Welfare Plan benefits.

A "return to work" is defined as working Disqualifying Employment which resulted in a Suspension of Benefits (as defined in the Midwest Operating Engineers Pension Plan).

If you return to work a second time, and are working in Disqualifying Employment which results in a Suspension of Benefits, you will no longer be eligible for Retiree Welfare Plan benefits. *There is one exception to this rule:* Eligibility for Retiree Welfare Plan benefits will not terminate if the Trustees determine that there is a need for the employment of retirees where there are no active employees available to perform such work. You must have a Temporary Waiver of Suspension of Benefits (as defined in the Midwest Operating Engineers Pension Plan) in order to maintain eligibility for Retiree Welfare Plan benefits. If you have a Temporary Waiver, you can forfeit active credits and stay in the Retiree Welfare Plan; you must complete a form to document this selection.

Once you retire, you can return to work as an active employee one time without affecting your eligibility for retiree benefits. A "return to work" is defined as working in disqualifying employment which resulted in a suspension of benefits. If you return to work a second time in disqualifying employment, it will result in a suspension of benefits and you will no longer be eligible for retiree benefits. However, if you return to work under the temporary waiver of suspension of benefits, you will not lose your eligibility for retiree benefits. Under the temporary waiver, you have the option to forfeit active credits and stay in the Retiree Welfare Plan. You must complete a form to document this selection.

If you return to active employment, you must make self-payments until you become eligible for the Active Plan. Failure to make these payments will result in termination of eligibility.

DEPENDENT ELIGIBILITY

In order to maintain coverage for your disabled child, you must submit proof of your child's physical handicap or mental incapacity to the Fund Office within 31 days of your child's 26th birthday.

During any benefit month that you are eligible for coverage, your eligible dependents are also covered. Eligible dependents include your spouse and children, as defined below:

- Your legally married spouse, other than a spouse separated by a decree of a court of competent jurisdiction.
- Your children up to the last day of the month that the child reaches age 26, including natural, adopted and stepchildren, regardless of student status, marital status or residence. **Note:** Stepchildren are not eligible for coverage if their relationship with you ends as the result of divorce or legal separation.
- Your handicapped children age 26 or older. While coverage normally ends on the last day of the month in which a dependent child reaches age 26, you can continue coverage for a handicapped dependent child. Children are considered handicapped when they are primarily dependent on you for financial support and maintenance because of a mental or physical condition that started before age 26. You must provide proof to the Fund Office that your child's handicap began before the child reached age 26. Coverage stays in force for as long as dependent coverage under the Plan continues and the child remains handicapped, as defined above.

MARRIED OPERATORS

If, as of June 1, 2019, you are an Operator and meet all of the eligibility requirements under this Plan, and you pre-decease your Spouse, your Spouse will be deemed Eligible for Retiree Benefits provided that the Spouse is:

- An Operator; and
- A member in good standing.

DISENROLLING DEPENDENTS FROM COVERAGE

To disenroll a dependent from Family coverage, the retired member needs to send a signed and dated letter to the Fund Office requesting which dependent to disenroll. The coverage will be terminated the first of the following month after the Fund Office receives the signed letter.

TERMINATION OF ELIGIBILITY

REASONS COVERAGE WILL END

You lose coverage if:

- You do not make the required self-payment on time,
- You die,
- The Plan terminates, or
- You do not remain a member in good standing.

Generally, your dependents lose coverage when you do. In addition, dependent coverage will end if:

- As to a spouse, you get divorced or become legally separated,
- A child no longer meets the definition of a dependent child,
- You disenroll a dependent from Family coverage, or
- A dependent dies.

SURVIVOR BENEFITS

SURVIVOR BENEFITS FOR RETIRED PARTICIPANTS

Survivor benefits apply if you were eligible under the Plan at the time of your death and you've been married to your spouse for at least one year at the time of your death.

If you die, your surviving dependents and/or spouse may remain covered by making self-payments. The amount of the required self-payment is determined by the Trustees and may change from time-to-time.

Your surviving spouse may elect to continue or delay coverage for himself or herself and all dependent children who could have been covered under the Plan on the day before your death. Upon your death, no other dependents can be covered by the surviving spouse under the Retiree Welfare Plan.

Effective January 1, 2019, a surviving spouse who has been married for less than one year prior to your death is not entitled to continue coverage by making self-payments. A surviving spouse who has been married for less than one year prior to your death may elect COBRA coverage.

SURVIVOR BENEFITS FOR ACTIVE PARTICIPANTS

Survivor benefits apply if:

- You were eligible under the Active Plan at the time of your death;
- You had met all of the retiree eligibility criteria but had not yet retired at the time of your death;
- You've been married to your spouse for at least one year at the time of your death; and
- You've met the age requirement to retire **or** your surviving spouse is entitled to a survivor's pension benefit, or was entitled to such a pension benefit but elected a lump sum distribution instead.

If you die, your surviving dependents and/or spouse may elect to continue coverage by making self-payments. The amount of the required self-payment is determined by the Trustees and may change from time-to-time.

Your surviving spouse may elect to continue or delay coverage for himself or herself and all dependent children who could have been covered under the Plan on the day before your death. Upon your death, no other dependents can be covered by the surviving spouse under the Retiree Welfare Plan.

Effective January 1, 2019, a surviving spouse who has been married for less than one year prior to your death is not entitled to continue coverage by making self-payments. A surviving spouse who has been married for less than one year prior to your death may elect COBRA coverage.

LOSING SURVIVOR BENEFITS

Your dependents' eligibility for Survivor Benefits will end under this Plan on the last day of the month following:

- The date the required self-payment is not made,
- The date of termination of this Plan,
- The date your spouse remarries,
- The date a child no longer meets the definition of a dependent,
- Your spouse's death,
- The date your spouse or dependent child becomes entitled to coverage under another group policy or plan including Medicare (only if you did not meet the age requirement to retire), or
- When your spouse establishes permanent residence outside the continental limits of the United States.

Survivor Benefit coverage is in lieu of COBRA and runs concurrently with the person's right to COBRA. If a surviving spouse elects to continue coverage under the MOE Retiree Health Plan and loses eligibility for one of the reasons explained above, any covered dependents may elect COBRA for the balance of the 36-month period from the beginning date of the Survivor Benefit coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs), which are court orders directing individuals to provide support for a dependent child in the event of a divorce or other family law action. Coverage will be provided to a child even if that child does not reside with the eligible member if that child is identified as an alternate recipient under a QMCSO. Orders must be submitted to the Fund Office to determine whether it is a QMCSO as required under federal law. You can receive a copy of the Plan's procedures for handling QMCSOs, at no cost, by calling the Fund Office.

Upon receipt of a QMCSO, the Fund Office will promptly notify you and each alternate recipient of the receipt of the order and provide you with the Plan's procedures for determining whether the order is a QMCSO.

CONTINUATION COVERAGE UNDER COBRA

Under a federal law called COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986), you and your eligible dependents can extend coverage temporarily at group rates ***after*** coverage would normally end, without providing evidence of good health. This extension of coverage is called *continuation coverage* or *COBRA coverage*.

Retiree Welfare Plan benefits are in lieu of COBRA. When an employee's eligibility as an active participant ends, he or she is offered a choice between COBRA coverage and Retiree Welfare Plan benefits. If the employee elects Retiree Welfare Plan benefits, he or she waives the right to COBRA coverage at a future date.

COBRA QUALIFYING EVENTS AND MAXIMUM COVERAGE PERIODS

Your spouse and dependent children have the right to COBRA continuation coverage for 36 months if their Retiree Welfare Plan coverage terminates because of one of the following events:

- You get divorced or become legally separated,
- A child no longer meets the definition of a dependent child, or
- Your death.

If a covered employee becomes entitled to Medicare benefits (either Part A or Part B) and later has a termination of employment or a reduction of employment hours, the period of COBRA coverage for the member's spouse and dependent children lasts until the later of the 36-month period that begins on the date the covered employee became entitled to Medicare, or the 18- or 29-month period that begins on the date of the covered member's termination of employment or reduction of employment hours.

SECOND QUALIFYING EVENT

A spouse and dependent children who already have COBRA coverage, and then experience a second qualifying event, may be entitled to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered member, divorce or legal separation from the covered member, the covered member becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child ceasing to be eligible for coverage as a dependent under the group health plan. The following conditions must be met in order for a second event to extend a period of coverage:

- The initial qualifying event is the covered member's termination or reduction of hours of employment, which calls for an 18-month period of continuation coverage;
- The second event that gives rise to a 36-month maximum coverage period occurs during the initial 18-month period of continuation coverage (or within the 29-month period of coverage if a disability extension applies);

- The second event would have caused a qualified beneficiary to lose coverage under the plan in the absence of the initial qualifying event;
- The individual was a qualified beneficiary in connection with the first qualifying event and is still a qualified beneficiary at the time of the second event; and
- The individual meets any applicable COBRA notice requirement in connection with a second event, such as notifying the plan administrator of a divorce or a child ceasing to be a dependent under the plan within 60 days after the event.

If all conditions associated with a second qualifying event are met, the period of continuation coverage for the affected qualified beneficiary (or beneficiaries) is extended from 18 months (or 29 months) to 36 months.

NOTIFICATION RESPONSIBILITIES

It is your (or your eligible dependent's) responsibility to provide written notification to the Fund Office within 60 days after:

- You and your spouse are divorced, or
- One of your children loses eligibility as a dependent under the Plan.

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office or that the Fund Office sends to you.

ELECTING COBRA COVERAGE

If your dependent chooses COBRA continuation coverage, he or she will be allowed to continue coverage under the Health Plan.

Your dependent will have to pay for the full amount of this coverage. Your dependent will be sent an election notice that includes the cost of the coverage. He or she will also be provided with the due dates and other pertinent information.

An election form will be sent along with the election notice. This is the form your dependent fills in and returns to the Fund Office if he or she wants to elect COBRA continuation coverage.

The person electing COBRA continuation coverage has 60 days after being sent the election notice or 60 days after coverage would otherwise terminate, whichever is later, to return the completed election form. An election of COBRA continuation coverage is considered to be made on the date the election form is personally delivered or mailed back to the Fund Office (the postmark date will govern the date of mailing).

If the election form is not returned to the Fund Office within the allowable period, your dependents will be considered to have waived their right to COBRA continuation coverage.

COBRA PAYMENT DUE DATES

Entitlement to COBRA Coverage shall be conditioned upon payment of monthly contributions determined annually by the Trustees, which shall not exceed 102% of the cost for providing health benefits to individuals in the same plan of benefits as the Qualified Beneficiary. However, the Trustees, in their discretion, may charge an amount up to, but not exceeding 150% of the cost for providing health benefits to individuals in the same benefit selection situation as the qualified beneficiary during the 19th through the 29th month of coverage for a qualified beneficiary who elects extended coverage because of disability. The Administrative Manager will provide specific cost information to the qualified beneficiary along with the notice of eligibility for COBRA Coverage.

A person electing COBRA continuation coverage has 45 days after the signed election form is returned to the Fund Office to make the initial (first) payment for coverage provided between the date coverage would have terminated and the date of the payment. (If you wait 45 days to make the initial payment, the next monthly payment may also fall due within that period and must also be paid at that time.)

COBRA continuation of coverage payments are due the first day of the month in order to receive coverage for that month. Your COBRA payment will be accepted if it is received by the Fund Office within a 30-day grace period after the due date.

For Example:

For March 1st coverage, your COBRA continuation of coverage payment is due March 1st. Your COBRA payment will be accepted as long as it is received within the 30-day grace period which ends March 30th. Payments received on March 31st will not be accepted.

Please Note: The Fund Office is unable to process any claims or prescriptions until your COBRA payment has been made for each coverage period.

If a COBRA payment is not made within the time allowed, COBRA continuation coverage for all affected family members will terminate. You may not make up the payment or reinstate coverage by making future payments.

COBRA SUMMARY

Reason for Loss of Coverage	COBRA Continuation for	Maximum Length of COBRA Coverage
Child no longer meets definition of dependent	Your child	36 months
Legal separation or divorce	Your spouse	36 months
You become entitled to Medicare coverage and lose coverage because of it	Your dependents	36 months
You die	Your dependents	36 months

COBRA continuation coverage will end earlier than the expiration of the 36-month COBRA continuation coverage period if:

- Your dependents become covered under another group health care plan with similar coverage,
- You or your dependents become entitled to/enrolled in Medicare,
- The Plan is no longer provided by the Midwest Operating Engineers Retiree Welfare Fund, or
- Your dependents fail to make the required contribution within 30 days after it is due.

OPTIONAL HEALTH CARE COVERAGE

FOR RETIREES AND DEPENDENTS WHO ARE NOT ELIGIBLE FOR MEDICARE

The Affordable Care Act provides you with an alternative to employer-sponsored health care coverage and COBRA continuation coverage: the Health Insurance Marketplace (the Public Health Exchange Marketplace).

The Public Health Exchange Marketplace offers health insurance options (called qualified health plans), which include comprehensive health care coverage, including physician and hospital-based services, as well as medications. Qualified health plans in the Public Health Exchange Marketplace present their price and benefit information in simple terms so that you can make apples-to-apples comparisons.

For more information about obtaining coverage through the Public Health Exchange Marketplace, visit **www.healthcare.gov**, contact EBSA electronically at **www.askebsa.dol.gov**, call the HealthCare.gov Help Line at 800-318-2596.

LIFE CHANGING EVENTS

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when different events occur. Please refer to page 5, regarding the notification requirements for certain Life Changing Events.

Under certain circumstances or Life Changing Events, as specified by law, a Participant may make a midyear election change. These events include marriage, divorce, birth of a child, death of a spouse or child, adoption of a child, gain or loss of eligibility of your dependents for group health plan coverage, insurance coverage, CHIP or Medicaid, and becoming eligible for state premium assistance, Medicaid, or CHIP subsidies.

GETTING MARRIED

When you marry, you can cover your spouse under the Retiree Health Plan. However, before claims can be processed for your spouse, you are required to submit documentation to the Fund Office to prove that he or she is your legal spouse. To do this, you can go to the My150 website and update "My FAMILY" to include your spouse as a dependent. Alternatively, you can call the Fund Office and request an Enrollment Form. Then complete the necessary information and return it to the Fund Office, along with a copy of your marriage certificate and a copy of the new spouse's Social Security card. Refer to page 5, regarding the notification requirements for coverage of a new spouse.

There are time limits involved when adding your eligible new dependents and when coverage begins. Refer to page 5 for details.

ADDING A CHILD

Your natural children will be eligible for coverage on their date of birth, but in order to be covered you must submit documentation to the Fund Office to prove that each child meets the Plan's definition of a dependent child. To do this, you can go to the My150 website and update "My FAMILY" to include your child as a dependent. Alternatively, you can call the Fund Office and request an Enrollment Form. Then complete the necessary information and return it to the Fund Office, along with a copy of each child's birth certificate or adoption papers and a copy of each child's Social Security card. Once you have submitted the proper proof, claims incurred on and after the date you elect to cover your child can be processed.

If you have or adopt a child

- Notify the Fund Office.
- Your child will be eligible for coverage on the date of birth or on the date of placement for adoption.

If a child is placed with you for adoption, he or she will be eligible for coverage on the date of placement as long as you are responsible for health care coverage, the situation meets the Plan requirements and you provide the required documentation within six months.

Stepchildren are eligible for coverage on the first of the month following the date of your marriage. See the *Dependent Eligibility* section on page 6, for the requirements for adopted children and stepchildren.

GETTING LEGALLY SEPARATED OR DIVORCED

You must submit a copy of your divorce decree or legal separation to the Fund Office. Your spouse's coverage will end at the end of the month in which the divorce or legal separation is decreed. Your spouse may elect to continue coverage under COBRA for up to 36 months (see *Continuation Coverage Under COBRA* starting on page 9). You or your spouse must notify the Fund Office within 60 days after the divorce date in order for your spouse to obtain COBRA continuation coverage.

CHILD LOSING ELIGIBILITY

In general, your child is no longer eligible for coverage when he or she reaches the limiting age or you elect not to cover/enroll that child. Your child's coverage will also end if the child enters active military service on a full-time basis (see *If a Dependent Enters the Military* below).

If your child loses eligibility, he or she may elect to continue coverage under COBRA for up to 36 months (see page 9). You or your child must notify the Fund Office within 60 days after your child no longer meets the Plan's definition of an eligible dependent to obtain COBRA coverage.

If your child is not capable of self-supporting employment because of a physical or mental handicap you may continue coverage for that child for as long as your own coverage continues and the child depends on you for the major portion of his or her support. To qualify, your child's disability must begin before his or her coverage would otherwise end.

If your child loses eligibility

- Contact the Fund Office immediately.
- Your child may elect to continue coverage under COBRA (see page 9).

Limiting age

Under the Plan, the limiting age for your dependent child is age 26.

DEATH OF A SPOUSE OR CHILD

Notify the Fund Office as soon as possible after the death of a dependent to change your dependent listing.

IN THE EVENT OF YOUR DEATH

If you die while eligible for coverage under the Plan, your spouse and children may be able to continue their health care coverage by making self-payments or electing COBRA continuation coverage. See page 7 for Survivor Benefits information and page 9 for information about COBRA.

MEDICAL BENEFITS
(COMPREHENSIVE MEDICAL BENEFITS)

The Plan covers a large portion of medical expenses for both you and your eligible dependents. In general, the Plan will provide benefits for eligible expenses incurred only while you or your eligible dependents are covered under the Plan. All of the following conditions apply when determining benefits.

Benefits are payable:

- Up to the stated benefit maximums,
- Up to the reasonable and customary limit (for non-PPO provider services) or up to the negotiated fee amount (for PPO provider services) or up to the Medicare-allowable amount (for Medicare-eligible retirees and dependents),
- For services rendered by an eligible provider,
- For treatment that is medically necessary and prescribed by a legally qualified physician and is not experimental or investigative.

HOW THE PLAN WORKS

When you (or any of your eligible dependents) receive medical services, the provider will usually file the claim for you with the Fund Office. Claims must be submitted within one year (12 months) after they are incurred. Even though the provider is submitting your claim, it is ultimately your responsibility to see that it is filed within the time limit.

After the Fund Office has processed your claim, a written Explanation of Benefits (EOB) will be sent to you. The EOB will show how much was applied to your deductible, how much the Plan paid, and the amount of the claim that is your responsibility to pay. The Fund Office processes claims in the order received, not in the order in which they were incurred.

FOR RETIREES WITH MEDICARE COVERAGE

When you become eligible for Medicare, you must enroll in Medicare Part A and Part B. Claims must be submitted with fully itemized bills and an Explanation of Medicare Benefits (EOMB). Refer to *Claims and Appeals* on page 47 for more information about claim filing. For information on Medicare crossover, see page 45.

DEDUCTIBLE

Each year, before the Plan pays anything for most eligible expenses, you pay the first dollars of eligible medical expenses. The amount you pay before benefits begin is called the "calendar year deductible." The calendar year deductible is $300 per person; payments toward individual deductibles are limited to a maximum of $700 per family.

The following example helps demonstrate how the individual and family deductibles work assuming all services are in-network.

For example, let's suppose you, your spouse, and your dependent child are covered by the Plan. Your family medical bills for the year look like this:

	Eligible Charges for		
Date of Medical Service	**You**	**Your Spouse**	**Your Child**
April	$300		
June		$500	
July			$400

We'll also assume that all of these charges are for in-network services and are covered by the Plan at 90% after the deductible is satisfied. Here's how benefits would be determined:

- In April, the Fund will process your expenses and issue an EOB showing the eligible charges and your responsibility to pay $300 out of your own pocket. This amount is credited toward your individual deductible.
- In June, the Fund will process your spouse's expenses and issue an EOB showing the eligible charges and your responsibility to pay $300 for the deductible out of your own pocket. The EOB will show a payment of $180 and your total responsibility will be $320 ($300 for the deductible plus 10% of the remainder).
- In July, the Fund will process your child's expenses and issue an EOB showing the eligible charges and your responsibility to pay $100 for the family deductible out of your own pocket. This is because your family's payments toward individual deductibles will have reached the $700 family deductible maximum. The EOB will show a payment of $270 and your total responsibility will be $130.

CARRYOVER

The Plan's "carryover" provision does not apply to any expenses that you or your dependents incurred while you or your dependents were covered under the Active Plan. The Plan's "carryover" provision applies only to expenses that your or your dependents incurred while you or your dependents were covered under this Retiree Plan. Any amount of eligible medical expenses incurred during the last three months of a calendar year (October, November and December) that are applied to a person's individual deductible will also be applied toward satisfaction of that person's deductible for the next calendar year. For example, if you did not incur medical claims until November and then met your individual $300 deductible, you wouldn't need to satisfy your deductible for the following calendar year beginning in January. The "carryover" provision is based on the date of service, not the date the claim was processed, and is subject to individual deductibles, but not to family deductibles.

COINSURANCE PERCENTAGES

After satisfying the deductible, you and the Plan share responsibility for additional eligible medical expenses. Generally, the member pays a lower coinsurance rate for in-network expenses and a higher coinsurance rate for reasonable and customary out-of-network expenses. The Plan pays the difference minus any non-covered services or amounts over the reasonable and customary allowances.

ANNUAL OUT-OF-POCKET MAXIMUM

Once your payments toward the annual deductible and copayments for covered medical charges reach the annual out-of-pocket maximum per person or per family, the Plan will pay 100% of the eligible expenses for the rest of the calendar year.

Expenses for temporomandibular joint disease (TMJ) treatment and orthoptic training do not count toward the annual out-of-pocket maximum. If you reach the out-of-pocket maximum, you will continue to pay 50% coinsurance for TMJ services and orthoptic training; the Plan will not pay 100% for TMJ services and orthoptic training after you reach a benefit out-of-pocket maximum.

Expenses that are not covered by the Plan do not apply toward the out-of-pocket limit. Expenses in excess of specific benefit maximums, and expenses covered under the Family Supplemental Benefit are not considered in determining the out-of-pocket limit. Amounts above the Plan's reasonable and customary allowance for covered out-of-network expenses do not apply to the out-of-pocket maximum.

MAXIMUM YEARLY BENEFIT

The maximum amount of comprehensive medical benefits payable for an eligible person under the Plan is $2,000,000 in a calendar year. Most paid medical benefits apply toward the maximum yearly benefit.

PPO PROVIDERS (For Retirees and Dependents Who Are Not Eligible for Medicare)

Retired participants and their dependents who are not eligible for Medicare have access to Preferred Provider Organization (PPO) providers. PPO providers offer discounts on services to you and your eligible dependents. When you use a PPO provider (also called an in-network provider), the Fund is charged a discounted rate for your care. The Fund shares these savings with you by reducing your out-of-pocket costs. When you use an out-of-network provider, your out-of-pocket costs may be higher because your care costs more. See page 18 for more information on PPO networks.

The Fund has contracts with the following types of PPO networks:

- Medical (hospitals, physicians, diagnostic imaging, mental health)
- Dental
- Prescription Benefit Manager
- Physical and occupational therapy
- Vision

REASONABLE AND CUSTOMARY (R&C) LIMITS

Charges by out-of-network providers are subject to the Plan's reasonable and customary (R&C) limits. An expense is considered R&C if the actual charge for the service or supply is comparable to what is usually charged for the same service or supply in the provider's geographic area. If you go to an out-of-network provider and you are charged an amount higher than the reasonable and customary fee, you are responsible for paying the difference between what this Plan pays and the actual expense. The amount you pay that is not R&C does not apply to the out-of-pocket maximum.

If you go to a PPO provider and are charged more than the negotiated fee for any given service, you will not be responsible for amounts above the negotiated fee. R&C limits do not apply to in-network provider services.

IF YOU RECEIVE SERVICES, *EITHER KNOWINGLY OR OTHERWISE* FROM AN OUT-OF-NETWORK PROVIDER, YOU WILL BE RESPONSIBLE FOR THE AMOUNT IN EXCESS OF THE R&C FEE, PLUS YOU WILL NOT BE ABLE TO TAKE ADVANTAGE OF THE IN-NETWORK DISCOUNTS.

For example, consider the following two claims for the same surgical procedure, one performed at a PPO surgical facility and one at a non-PPO surgical facility.

	In-Network	Out-of-Network
Billed Charges	$12,750	$12,750
Network Discount	$8,150	$0
Allowable Amount	$4,600 (billed - discount)	$6,500 (R&C)
Fund Benefit	90%	80%
Fund Paid Amount	$4,140	$5,200
Patient's Responsibility	$460 (10% copayment)	$7,550 Note: The 20% copayment ($1,300) applies to the out-of-pocket maximum; the remainder does not apply
Patient's Savings	**$7,090**	

As you can see, you can save a lot of money if you use PPO providers.

Retirees and their dependents who are eligible for Medicare should use Medicare-approved hospitals, physicians and suppliers. The Plan will allow the amount approved by Medicare for an eligible expense, and will coordinate benefits based on Medicare's payment.

USING PPO NETWORKS

Retirees and dependents who are not eligible for Medicare should use the Plan's PPO networks. Medicare-eligible retirees and dependents should use providers approved by Medicare.

YOUR HOSPITAL AND PHYSICIAN PPO NETWORK

You can go to any eligible medical provider for your health care needs. However, you'll receive a higher level of benefits and save money on your covered health care expenses when you go to a doctor or hospital that participates in the local PPO network. (As explained below, diagnostic imaging services are provided through the Plan's diagnostic imaging network. In addition, as explained in the *Dental Benefit* section, there is a separate Dental PPO network for dental services.)

If you live outside Illinois, you can use providers in the national PPO network, which is a network of hospitals and physicians throughout the United States that participate in their local PPO networks.

PPO providers work in partnership with the Fund to provide cost-effective, quality health care to you and your covered family members. At the time you receive treatment, please verify that the provider is still in the network.

If your primary care physician recommends surgery, make sure the surgeon and facility are in the PPO network. Also, your children who are away at school should ask about PPO participation whenever they seek medical care.

YOUR MEDICAL IDENTIFICATION (I.D.) CARD

The Medical Identification Card indicates that eligible retirees and dependents have access to the Plan's local and national PPO networks. Whenever you visit a PPO provider, show your I.D. card. Your health care provider will file your claim for you, and your claims will be processed as quickly as possible.

YOUR VENDOR INFORMATION CARD

The Vendor Information Card contains information pertaining to most vendors contracted with the Retiree Welfare Fund. Please present this card to your provider at the time services are rendered.

DIAGNOSTIC IMAGING NETWORK

If your doctor orders an MRI or CT scan for you or one of your covered dependents and you use an in-network provider, the Plan pays 100% (after the annual deductible) for covered scans. Otherwise, the Plan pays a percent of the R&C limits for out-of-network providers.

THERAPY NETWORK

If you are in need of physical or occupational therapy, you can visit an ATI Physical Therapy provider for treatment, at no cost to you. ATI Physical Therapy works directly with the Case Manager to get treatment certification (see below). If you choose to see a provider other than ATI Physical Therapy, you will be responsible for the deductible and/or coinsurance, as shown on your Schedule of Benefits.

SERVICES REQUIRING CERTIFICATION BY THE CASE MANAGER*

The Plan's Case Manager must approve certain services and supplies, including, but not limited to:

- Cochlear implants and auditory brainstem implants,
- Home health care,
- Intensive outpatient program for mental health or substance abuse,
- Medical equipment costing $l,000 or more,
- Medical orthodontia (TMJ, jaw disorders),
- Outpatient physical therapy,
- Outpatient occupational therapy,
- Skilled nursing facility care,
- Outpatient speech therapy,
- Partial hospitalization programs for mental health or substance abuse,
- Transplants,
- Outpatient surgical procedures,
- Inpatient hospital services,
- Sleep apnea appliances,
- Residential mental health or substance abuse facilities,
- Orthoptic training,
- Prosthetics,
- Continuing care.

If not on this list, please contact the Fund Office to verify if your service needs certification.

*This program is for retirees and dependents who are not eligible for Medicare. Medicare-eligible retirees and dependents should follow Medicare's procedures.

NETWORK AND CERTIFICATION REQUIREMENTS SUMMARY

For This Situation	You Must Contact This Provider	Telephone Number
Transplant services, case management (home health care, skilled nursing facility care, medical equipment, etc.), and mental health	Valenz Care	855-298-0493
Case management for outpatient physical/ speech/occupational therapy	Contact Valenz Care or ATI Physical Therapy; if you contact ATI Physical Therapy they will coordinate certification with Valenz Care	Valenz Care: 855-298-0493 ATI: 833-284-0001

ELIGIBLE MEDICAL EXPENSES

This section describes the types of medical expenses covered by the Plan. Even if an expense is listed in this section, it will be covered only up to the R&C limit (please refer to page 17) and only if the service or supply is medically necessary.

"MEDICALLY NECESSARY" MEANS SERVICES AND SUPPLIES THAT:

- Have been established as safe and effective by the American Medical Association or appropriate governing body;
- Are furnished in accordance with generally accepted professional medical standards for treatment of illness and injury;
- Are consistent with the signs, symptoms or diagnosis and treatment of an illness or injury;
- Are not primarily for the convenience of the eligible person or his or her doctor;
- Are the most appropriate supply or level of service which can be safely provided;
- Are necessary and appropriate treatment of the illness or injury;
- Are not experimental or investigative in nature; and
- Are not cosmetic in nature; that is, the treatment restores or repairs function.

PREVENTIVE CARE FOR RETIREES AND SPOUSES

- **Routine physical examination benefit, including:**
  - Physician's charges for a routine annual physical examination,
  - Mammogram (2D and 3D mammogram screenings). Note: 2D and 3D diagnostic mammograms are not considered preventive care and will be subject to the Plan deductible and coinsurance,
  - Hearing examination provided by a physician or licensed audiologist,
  - Employment physical,
  - Immunizations, and
  - Influenza shots.

  Only retirees and their dependent spouses are eligible for this benefit, up to the maximum benefit specified in the Schedule of Benefits.
- **Well Baby Care Benefit.** Expenses for outpatient and office visits and routine childhood immunizations for a dependent child from birth through age 24 months.

  Plan coverage is not available to a newborn child of an individual covered as a participant's dependent child.

Unlike active health plans, the Affordable Care Act (ACA) does not require retiree health plans to cover certain preventive care services.

COVERED SERVICES

- **Hospital services and supplies.**
  - Room and board at the most common semi-private rate (or the room and board charge for the intensive care unit or private room if the disease is contagious), if required for treatment due to an injury or illness.
  - Miscellaneous services and supplies during hospital confinement. These include medically necessary hospital supplies and services, x-rays, charges for ambulance service, emergency room, anesthetist, radiologist, pathologist and charges made for unreplaced blood. The Plan does not cover any expenses incurred if you are admitted to the hospital more than one day before non-emergency surgery or on the weekend, unless it is medically necessary.
  - Pre-admission diagnostic tests, including those performed on an outpatient basis (one set of tests per surgery). These tests must be related to the condition for which you will be hospitalized, and accepted and not duplicated by the admitting hospital.
  - Emergency room and outpatient hospital services.
  - Implants, provided that the invoice from the supplier is submitted.
- **Outpatient ambulatory surgical center services and supplies.** The surgical center must be licensed by the state in which it operates.
- **Physicians' professional medical and surgical services as follows:**
  - Hospital, office and home visits.
  - Emergency room services.
  - Surgeon's and assistant surgeon's services. Expenses for outpatient surgical supplies are included in the physician's fee. The Plan covers orthognathic (jaw) surgery performed by a physician or dentist when deemed medically necessary by the Case Manager. The maximum allowable amount for an assistant surgeon is 25% of the allowable amount for the primary surgeon. If the assistant is not a medical doctor, but is a physician assistant, surgical assistant or registered nurse, the maximum allowable amount is 17% of the allowable amount for the primary surgeon.
  - Second and third surgical opinions. Second and third surgical opinions are covered, including any diagnostic tests, when the consultations are provided by Board-certified surgeons.
  - Anesthesia administration.
  - Blood replacement administration.
- **Diagnostic x-rays and laboratory tests.**
- **Pregnancy and maternity care as follows:**
  - The Plan will provide maternity benefits for the mother (when a member or the spouse of a member) and her newborn infant for at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarean section. The Plan will not require Case Manager approval for a length of stay not in excess of these periods. (The attending provider may, however, after consultation with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Caesarean section.) Maternity care will be paid the same as any other covered illness.
  - Home delivery by an M.D.
  - Abortions, limited to once in a 12-month period. Evidence of medical necessity must be provided for termination of a pregnancy in the second or third trimester.

- **MRIs, PET and CT scans**. These scans are payable at 100% (after your deductible) if you use a facility in the diagnostic imaging network.
- **Physical therapy performed on an outpatient basis** due to an injury or illness when approved by the Case Manager.
- **Occupational therapy performed on an outpatient basis** due to an injury or illness, including but not limited to stroke, brain tumor, brain trauma or heart attack. The therapy must be approved by the Case Manager.
- **Physical and occupational therapy for congenital neurological diseases for individuals through age 18 only**. The therapy must be approved by the Case Manager. Congenital neurological diseases includes, but is not limited to, cerebral palsy, muscular dystrophy, Down's Syndrome and Edward's Syndrome. The age limit will not apply to an individual who satisfies the Plan's definition of an eligible dependent because he or she is incapable of self-sustaining employment by reason of mental retardation or physical handicap.
- **Speech therapy, as follows (approval by the Case Manager is required):**
  - Restorative speech therapy performed on an outpatient basis, when medically necessary to restore speech that was lost or impaired as a result of an illness or injury.
  - Developmental speech therapy, including therapy for congenital neurological disorders and pervasive developmental disorders.
  - Refer to your Schedule of Benefits for speech therapy limitations.
- **Chiropractic care,** that is medically necessary, but only up to the maximum benefits specified in the Schedule of Benefits.
- **Hemodialysis or peritoneal dialysis and supplies administered on an outpatient basis** under the direction of a physician including x-rays, laboratory examinations and technician charges, unless the charges would have been covered under Medicare. (If you are on dialysis for more than 30 months, Medicare becomes primary.)
- **Radiation therapy administered on an outpatient basis**, including the rental or use of radioactive substances, and the outpatient doctor or technician charges.
- **Chemotherapy administered on an outpatient basis**, including the outpatient doctor or technician charges, and chemotherapy drugs.
- **Allergy injections and their administration.**
- **Orthoptic training** in lieu of surgery for dependent children under age 10. Refer to your Schedule of Benefits for limitations.
- **Medical supplies and devices, as follows:**
  - Prostheses and support devices, including colostomy bags and necessary supplies required for attaching. We recommend that you request verification from the Fund Office that the device is an eligible expense under the Plan. Case Manager approval is required for a prosthetic device.
  - Foot orthotics prescribed by a medical doctor, podiatrist or chiropractor are covered; refer to your Schedule of Benefits for plan limitations.
  - Custom-fitted shoes are not considered orthotics and are not covered.
  - Dressings, casts, splints, trusses, braces and crutches.
  - Anesthetics.
  - Blood and blood plasma.
  - Oxygen and the rental of equipment for the administration of oxygen, subject to approval by the Case Manager.
- **Durable medical equipment which meets all of the following qualifications:**
  - It is for repeated use and is not a consumable or disposable item;
  - It is used primarily for a medical purpose; and
  - It is appropriate for use in the home.

Examples of durable medical equipment include hospital beds, wheelchairs, hemodialysis equipment, intermittent positive pressure breathing machines, walkers, crutches, canes, oxygen walker units and percussors. For purposes of determining the total allowable expense, the cumulative cost of equipment rental or lease is limited to the actual cost of equipment purchase. Note that equipment used for comfort only and rental costs greater than the actual purchase price of the equipment are not covered. An exception will be made if the durable medical equipment does not have a purchase price and it is necessary to continue payment unless the medical necessity ends.

Replacement is covered if there is a change in the person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser cost.

The maximum benefit payable for an electronic or mechanized wheelchair is $15,000.

In general, the replacement of durable medical equipment is limited to one every five years unless the Plan determines that an earlier replacement date is appropriate due to no fault of yours. For instance, when there is a change in your condition, or the equipment cannot or is too costly to be repaired.

- **Mental health treatment** (treatment of a mental illness or substance abuse). The Plan also provides a Member Assistance Program (MAP) that can provide you and your eligible dependents with confidential assessment and referral services for your personal issues.
- **Repair to oral/facial structures due to accidental injuries including,** but not limited to, jaw and facial bone fractures and sound natural teeth, provided the service is rendered within 12 months of the accident.
- **Oral apnea appliances** recommended by a physician and supplied by a physician or dentist, subject to limitations. No benefits will be paid for an initial or replacement appliance if the Case Manager does not certify the device to be Medically Necessary. In general, the replacement of an existing sleep apnea appliance is limited to one every five years unless the Plan determines that an earlier replacement date is appropriate due to no fault of yours. For instance, when there is a change in your condition or the appliance cannot or is too costly to be repaired.
- **Orthodontic treatment of TMJ**. Expenses for temporomandibular joint disease (TMJ) treatment do not count toward the annual out-of-pocket maximum. If you reach the out-of-pocket maximum, you will continue to pay 50% coinsurance for TMJ services; the Plan will not pay 100% for TMJ services after you reach a benefit out-of-pocket maximum.
- **Orthognatic (jaw) surgery** when performed by a physician or dentist and deemed medically necessary by the case manager.
- **Organ transplants.** The following human-to-human transplant procedures are covered when approved by the Case Manager and performed at an in-network facility:
  - Bone marrow (self-and other-donated),
  - Heart,
  - Lung,
  - Liver,
  - Kidney,
  - Cornea.

A patient eligible for Medicare must use a Medicare-approved provider.

The Plan does not cover:

- Transplants paid for by governmental foundation or charitable grants,
- "Sold organs" (the amount charged to purchase an organ), or
- Donor searches of individuals who are not immediate family members (i.e., parents and siblings) for transplants, including HLA typing to determine a transplant match. However, if the individual has no immediate family members, he or she may obtain HLA typing for up to two non-family members. For this purpose, the Plan will consider the individual as having no immediate family members under specific circumstances as follows:
  - The individual has no immediate family members who are alive and are a donor match;
  - The individual has no immediate family members who are a donor match and can serve as a donor without causing harm to himself;
  - The individual made documented attempts to obtain a donor match from an immediate family member and no immediate family member is willing to participate.

The following limits also apply:

- $10,000 for transportation and lodging, and
- $10,000 for private nursing care.

These benefits do not apply to the regular yearly maximum benefit.

- **Cochlear implants and auditory brainstem implants** that have been approved by the Case Manager.
- **Medical transportation services, as follows:**
  - Initial transport. Ground or air ambulance transportation by a professional ambulance service from the site where the injury, medical emergency or acute illness occurs to the nearest appropriate facility;
  - Inter-facility transfer. Transfer from one health care facility to another when the second facility is the nearest appropriate facility for the treatment of the medical emergency. The maximum allowable expense for an inter-facility transport will be $5,000. The $5,000 limit will not apply if the Case Manager determines that the additional charges are medically necessary and that no less-costly form of transport would have been appropriate due to the patient's health status; and
  - Ground non-emergency ambulance transfer from a hospital to your home is limited to less than 100 miles from the hospital if you are discharged from the hospital directly into home hospice care.
- **Nursing services** provided by a registered nurse, advanced practice nurse or nurse practitioner.
- **Home health care services** provided by a licensed home health care agency, provided that the plan of care is approved as medically necessary by the Case Manager, prescribed by a physician (M.D. or D.O.), and reviewed and approved by the physician during the entire period.
- **Licensed skilled nursing facility confinement** recommended and supervised by a physician that begins within 30 days of a hospital confinement for the same cause. Coverage is limited to 45 days per period of confinement. Successive confinements will be considered one period of confinement unless the patient has a break in the confinement. If the break is less than 30 days, the confinement will be treated as part of the same benefit period. If the break is 31-60 days, a three-day hospital stay is required for additional skilled nursing benefits up to a 45-day maximum.
- **Intrauterine devices (IUDs), Norplant and Depo-Provera injections.**
- **Acupuncture** performed by a physician, or licensed acupuncturist when referred by a physician (M.D. or D.O.), subject to the limitations specified in the Schedule of Benefits.
- **MinuteClinic.** Many MinuteClinic services will be free of charge. However, cash payment will be required for certain services. For a current list of covered and cash-pay services, visit **www.moefunds.com.**
- **Lap band adjustments** authorized by the Case Manager.

- **Surgery related to obesity** and any second such surgery in your lifetime deemed Medically Necessary by the Case Manager; provided that any first or second surgery related to obesity is subject to the Plan's Reasonable and Customary Charge rules.
- **Prophylactic Surgery/Mastectomy/Oophorectomy.** A mastectomy and oophorectomy will be covered if Medically Necessary for individuals who carry the BRCA1 or BRCA2 gene mutation. In the case of an individual who is receiving benefits in connection with a mastectomy, the plan shall provide coverage for the following benefits for individuals who elect them: All stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce and symmetrical appearance; Prostheses; and Treatment of physical complications of mastectomy, including lymphedema, in a manner determined in consultation with the attending provider and the individual.
- **Pediatric Feed and Swallowing Therapy.** Therapy must be deemed Medically Necessary and subject to approval by a Case Manager.

EXCLUSIONS

No comprehensive medical benefits will be payable for:

- Care and treatment that is not medically necessary;
- Charges which exceed the maximum benefits allowed under the Plan;
- Illness or injury that is related to any occupation or employment for wages or profit;
- Genetic testing, except HLA typing and Oncotype DX genomic assay genetic testing as required for chemotherapy treatment as approved by the Case Manager;
- Cosmetic surgery or treatment, except for treatment of an accidental injury or for a congenital anomaly in dependent children. Surgery or treatment for complications arising for non-covered cosmetic surgery or treatment is also excluded;
- Reconstructive surgery, except for the following:
  - When performed to improve the function of a body part when the malfunction is the direct result of congenital defect, developmental abnormality, infection, tumor, disease or trauma;
  - When performed to remove scar tissue on the neck, face or head; and
  - Breast surgery following a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Reversal of sterilization, hormone therapy, artificial insemination, in vitro fertilization, GIFT, ZIFT, or any other direct attempt to induce or facilitate fertility or conception, with the exception of services and supplies for the diagnosis of infertility;
- Vocational therapy;
- Services rendered by athletic trainers, kinesiologists, massage therapists, recreational therapists, non-licensed therapy aides/assistants or any other non-therapist professionals, even if an eligible provider is supervising the therapy or billing for the treatment;
- Routine foot care such as removal of corns or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches and chronic foot strain;
- Immunizations, routine physical examinations, or physical examinations or medical certificates required for employment, except as specifically stated otherwise;
- Surgical or laser correction of myopia and/or other refractive errors (such as Lasik);
- Diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies;
- Hearing aid devices, including, but not limited to, hearing aids;

- Personal convenience or comfort items including, but not limited to, such items as televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- Examinations or treatment ordered by a court in connection with legal proceedings, unless such examinations or treatment would otherwise qualify as an eligible expense and the provider of the service meets the definition of a physician, hospital or eligible provider;
- Any operation or treatment for teeth and gums, except for tumors, or cysts (if removal requires a surgical facility, and if approved by the Case Manager), or repair of injury to sound natural teeth which occurs within 12 months of the accident;
- Telephone and telemedicine consultations or e-visits;
- Weight loss programs such as Jenny Craig, Nutri-Systems, etc., including nutritional counseling;
- More than two surgical procedures for obesity per lifetime (the surgery must be authorized);
- Wigs or toupees, hair transplants, hair weaving or any drug in connection with baldness;
- Medical, surgical, psychiatric or prescription drug treatment related to transsexual (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures;
- Any expenses that are not listed as eligible medical expenses on pages 20-25;
- Treatment for substance abuse or mental illness other than as specifically stated on page 23;
- Transplants which are not listed on pages 23 and 24;
- Psychological testing (covered for certain diagnosis);
- Diabetic test strips and lancets;
- Family therapy, unless it includes the dependent child as approved by the Case Manager;
- Group therapy unless part of intensive outpatient or partial hospitalization programs;
- Treatment or medication which is experimental or investigational; or
- Expenses specified as not payable in the *General Exclusions* section that starts on page 42.

OPERATORS' HEALTH CENTER

The Plan provides the Operators' Health Center (OHC), an on-site health center that offers certain medical care services at no cost to you or your eligible dependents age two and over. A dependent child under the age of two who is brought to the Operators' Health Center will be recommended to a network pediatrician.

Care	Services Covered at 100%
Preventive Care	• Annual physical exam • Basic health screening – Cholesterol – Diabetes – Blood pressure • Biometric screening • Health risk assessment • Hearing examination • Immunizations • Influenza shots • Women's health • Skin, breast and prostate cancer screenings
Wellness Visits	• Ear wax removal • Motion sickness prevention • One-time medication renewal • Pregnancy evaluations • Tuberculosis testing • DOT Physicals
Minor Illnesses	• Allergy symptoms • Epipen and Twinject refills • Bronchitis and coughs • Earaches and ear infections • Flu-like symptoms • Mononucleosis (mono) • Pink eye and styes • Sinus infections and congestions • Sore and strep throat • Upper respiratory infections • Urinary tract and bladder infections
Minor Injuries	• Insect bites and stings • Minor burns • Minor cuts, blisters and wounds • Splinter removal • Sprains and strains (ankle and knee only) • Suture and staple removal • Tick bites

Care	Services Covered at 100%
Skin Conditions	• Acne • Athlete's foot • Skin rashes • Cold, canker and mouth sores • Eczema • Impetigo • Lice • Poison ivy and poison oak • Ringworm • Scabies • Shingles • Styes • Sunburn
Treatment and Procedures	• Basic splinting • Basic wound care • Ingrown toenail removal • Nebulizer treatment • Peak flow testing • Physical therapy (Merrillville only) • Skin biopsy • Skin cyst removal • Skin tag and wart removal (cryo) • Stitches • Suture/staple removal
Laboratory Services	• Blood draws and sample collection • Hemoglobin A1C • Lung function screening • Pregnancy test • Standard annual tests • Stool blood test (fobt) • Strep throat test
Chronic Disease Monitoring	• Diabetes monitoring including HbA1C checks • High blood pressure monitoring • High cholesterol monitoring

PRESCRIPTION DRUG PROGRAM

The prescription drug program provides benefits for covered prescription drug expenses when you fill your prescriptions at a pharmacy in the pharmacy benefit manager's (PBM's) network or through the PBM's Mail Service Pharmacy. Currently, the PBM is OptumRx.

Note:

Prescription drugs used for the treatment of cancer and IV infusion drugs are covered under the comprehensive medical benefit.

PRESCRIPTION DRUG BENEFITS

You have two options for filling a prescription drug:

- An in-network retail pharmacy
- The OptumRx Mail Service Pharmacy

When you fill a prescription at an in-network retail pharmacy or the OptumRx Mail Service Pharmacy, you'll pay a discounted rate, as specified in the Schedule of Benefits. When prescriptions are filled at an out-of-network pharmacy, no benefits are payable. You are responsible for 100% of the cost of the medication, and no reimbursement is allowed.

What you pay for prescription drugs filled at in-network pharmacies depends on the medication's tier. In general, the tiers are:

- **Tier One:** Generic drugs listed on the formulary
- **Tier Two:** Preferred brand name drugs listed on the formulary
- **Tier Three:** Non-preferred brand name drugs listed on the formulary
- **Specialty Drugs:** Drugs used to treat rare or complex conditions that may require special storage and handling. You may be required to fill these at a Specialty Pharmacy.

Certain high-cost generic and brand name drugs may appear on a higher tier. Check the formulary to determine the tier your prescriptions are on.

If the cost of the medication is less than your copay, you will pay the lesser amount.

MAXIMUM ANNUAL BENEFIT

Prescription drug benefits are limited to $30,000 per person each calendar year. This benefit cannot be shared or transferred between eligible individuals. If you exceed the maximum benefit for the calendar year, you are responsible for 100% of the cost of the medication for the remainder of the calendar year and can be reimbursed through the Family Supplemental Benefit (FSB).

Certain drugs may not be subject to the annual limitation as provided in the Schedule of Benefits. For example, prescription drugs used for the treatment of cancer covered under the comprehensive medical benefit are not subject to the Maximum Annual Benefit.

FILLING A PRESCRIPTION

Whenever you fill a prescription at an in-network pharmacy, please be sure to present your vendor information card to the pharmacy staff. This card contains all pertinent billing information required to process your prescription claims.

If your prescription does NOT properly bill through the Plan, for any reason, after you have presented your vendor information card to the Pharmacy Staff, promptly call the Pharmacy Benefit Department at 708-387-8331. There is a reason that the prescription is not going through so please be sure to contact us so our staff can investigate what is going on. Claims can usually be re-processed at a Pharmacy within seven days that the prescription was originally processed, and an accurate refund can be issued by the pharmacy. The Pharmacy Benefit Department cannot issue reimbursement for out-of-pocket expenses outside of the seven day window mentioned above, and cannot be reimbursed through the Family Supplemental Benefit (FSB).

SHORT-TERM MEDICATION:

These prescriptions can be filled at any in-network pharmacy:

- Indicate to your physician which pharmacy you would like your prescription filled at, along with the location, so they can call, fax or electronically submit your prescription to be processed.
- You may receive up to two **30-day supplies** of a short-term medication, but if you seek a third refill of that medication it is no longer considered short-term. When seeking a third refill it is now considered a long-term medication (maintenance medication), and you must transition to a CVS retail pharmacy or to the OptumRx Mail Service Pharmacy to obtain a 90-day supply.

Prescription drug benefits will be paid for prescriptions on the **OptumRx Select Formulary.**

To locate an in-network pharmacy closest to you, login at **www.optumrx.com** and click on the "Pharmacy Locator" on the right side of the page.

LONG-TERM MEDICATION (MAINTENANCE MEDICATION):

These prescriptions can be filled at a CVS retail pharmacy or the OptumRx Mail Service Pharmacy:

Indicate to your physician which CVS location you would like your prescription filled at OR indicate that you would like to use the OptumRx Mail Service Pharmacy for a 90-day supply. Please be aware that the prescription **must** be written for a 90-day supply when using the OptumRx Mail Service Pharmacy. If the prescription is written for anything less than 90-days, you will still be responsible for paying a 90-day copayment.

Your physician can then:

- Call in your prescription,
- Fax your prescription,
- Electronically submit your prescription, or
- If you decide to utilize the OptumRx Mail Service Pharmacy, you may also mail the original written prescription along with the Mail Service Order Form to:

  OptumRx
  P.O. Box 2975
  Mission, KS 66201.

To find and print the Mail Service Order form visit **www.optumrx.com.** Click on "Information Center" and then "Forms." The Mail Service Pharmacy form is listed under "Other Forms." To obtain additional information regarding the OptumRx Mail Service Pharmacy please call 855-697-9150.

PRIOR AUTHORIZATIONS

Certain medications require a Prior Authorization (PA) to be completed by OptumRx before the medication can be filled. If a required PA is not completed and is paid out-of-pocket, no reimbursement is allowed.

The following medications will require prior authorization to determine coverage:

- All testosterone products;
- Analgesics (opioid);
- Allergen extracts;
- Compounded drugs that exceed $300;
- Other specialty and non-specialty drugs; and
- Non-preferred drugs that are subject to the step therapy program.

Medications that require a PA are subject to change in accordance with the formulary.

"NEW TO MARKET" DRUGS

Any medication that is newly-approved to market by the U.S. Food and Drug Administration (FDA) is not covered by the Fund until after OptumRx has had a chance to review the evidence and overall clinical value when compared to other alternatives in the market. No payment will be made for a "new to market" drug before OptumRx has completed its review. Even after review, there is no guarantee of coverage for the "new to market" drug, and if you fill the medication, you are responsible for 100% of the cost of the medication; no reimbursement is allowed.

STEP THERAPY

You may be required to try a preferred medication before the Fund will cover a non-preferred medication. In order for benefits to be paid for a non-preferred medication prior to a preferred medication, a PA is required. If approved, a higher copayment may apply. If the request is denied and you continue to fill the prescription, you are responsible for 100% of the cost of the medication; no reimbursement is allowed.

APPEALS

You have the right to file an appeal with the Fund for any denied medication. The appeals process follows the same procedures as outlined on page 47.

LIMITATIONS

If there is a brand name medication that has a generic equivalent available and you choose to take the brand or your provider indicates brand only on your prescription, a "brand name penalty" will be assessed. This means that you must pay the difference between the cost of the brand name drug and the generic drug PLUS the brand name copayment, unless determined medically necessary through the appeals process.

Medication used for the treatment of Erectile Dysfunction (ED) is covered and payable according to the Schedule of Benefits if you visit the Operators' Health Center (OHC), and designate them as your primary care provider. A quantity limit of 10 tablets per 90-days applies. If you do not use the OHC, then you are responsible for 100% of the cost of the medication and can be reimbursed through the FSB.

When prescriptions are filled at an out-of-network pharmacy, no benefits are payable. You are responsible for 100% of the cost of the medication, and no reimbursement is allowed.

Dispensing quantities and daily limits are subject to FDA's intended and approved usage. For specific questions pertaining to drug limitations, call OptumRx at 855-697-9150.

ELIGIBLE EXPENSES

The following supplies, authorized by a physician, will be considered covered expenses under the prescription drug program:

- Legend drugs, which are lawfully obtainable only from an individual, licensed to dispense drugs upon the prescription of a physician;
- Drugs for the intent of administration by a licensed provider;
- Certain diabetic supplies unless otherwise excluded;
- Prescription oral, transdermal and injectable contraceptives; and
- Compounded drugs, as long as one ingredient is covered through the Plan. Compounded drugs, exceeding $300 require prior approval. Must be billed properly through the Plan and filled at an in-network pharmacy.

EXPENSES NOT COVERED

You must use an in-network pharmacy. When prescriptions are filled at an out-of-network pharmacy, no benefits are payable. You can determine if a pharmacy is in-network by phone or online. No benefits will be payable under the prescription drug program for:

- Non-legend or over-the-counter drugs;
- Drugs prescribed to exceed 90 days per fill;
- Drugs dispensed for use while you are hospital-confined;
- Contraceptive devices that are not specifically stated as covered;
- Drugs that promote hair growth;
- Drugs that are intended to promote fertility, unless prescribed for a medical condition other than infertility;
- Abortifacients;
- Non-drug items;
  - Vitamins and nutritional supplements;
  - Comprehensive weight management programs;
  - Blister packaging, bingo cards or any other medication packaging solution;
  - Support garments, adult diapers, pill-cutters and pill organizers;
- Drugs dispensed at a physician's office, hospital outpatient or other facility;
- Experimental drugs or drugs intended for experimental or investigational treatment as determined by the Trustees or when the federal label states "Caution: Limited by federal law to investigation use," or drugs that are not prescribed or used in a manner consistent with the manufacturer's and the FDA's intended and approved usage, except when the Case Manager certifies that the usage has become the standard of care;
- Drugs prescribed for a cosmetic purpose except when medically necessary;
- Drugs prescribed in connection with a procedure that is not covered under this Plan, including, but not limited to, any complication that arises as a result of a non-covered procedure;
- Medicine and drugs that do not require a prescription to purchase;
- Any prescription drug purchased under another group health plan;
- Maintenance medications dispensed during an outpatient procedure that are not related to treatment received during that outpatient procedure;
- Durable Medical Equipment except certain continuous glucose monitors; a prior authorization must be completed before coverage is considered;
- Medication used for the treatment of Erectile Dysfunction unless otherwise specified; or
- Blood glucose meters, blood glucose test strips, and lancets if covered under Medicare Part B.

CONVALESCENT AND NURSING HOMES

If the convalescent and nursing home is using an in-network pharmacy, prescription drugs will be covered as outlined in this section. If an out-of-network pharmacy is being used, prescription drugs will be covered at 50% of the actual cost of the medication. Contact the Pharmacy Benefit Department at 708-387-8331 for additional information.

COORDINATION OF BENEFITS

The Plan does not coordinate prescription drug benefits with any other insurance plan. If a claim is submitted to any other insurance plan, no benefits will be paid under this Plan.

RESOURCES

OPTUMRX CUSTOMER CARE CALL CENTER

You can contact the OptumRx Customer Care Call Center at 855-697-9150 to update your form of payment, order a refill, track an order, update your address and much more.

ONLINE

Register online at **www.optumrx.com** where it is easy to order refills, manage your auto refills, view your prescription history, request a new prescription and access a host of health resources. You can also visit **http://moefunds.com/pharmacy/** for more information regarding the pharmacy benefit.

OPTUMRX MOBILE APPLICATION

The OptumRx app is another valuable resource allowing you to:

- Refill prescriptions,
- Pick up prescriptions with your phone,
- Stay on schedule with medication reminders, and
- Manage prescriptions.

GENERAL INFORMATION ABOUT THE PROGRAM

If you have questions about your prescription drug benefits, please call the Pharmacy Benefit Department at 708-387-8331.

DENTAL BENEFIT

Dental care benefits are available to you and your family.

HOW BENEFITS ARE PAID

To file a claim for covered dental services, submit a completed dental claim form to Delta Dental within one year (12 months) after they are incurred. Even though the provider may be submitting your claim, it is ultimately your responsibility to see that it is filed within the time limit.

There is no deductible to satisfy before benefits begin. Benefits payable (other than for preventive services) are based on a maximum allowable fee on the type of service received.

Type of Eligible Dental Expense	Reimbursement Percentage
Preventive Services (exams, cleanings and bitewing x-rays)	100%
Basic and Major Services (fillings, crowns, root canal therapy, oral surgery, dentures, bridgework and other covered dental services)	70%
Orthodontics (children under age 19)	50%

The Plan pays up to $1,500 per person in benefits each calendar year for covered dental services. There is no calendar year maximum for dependent children under age 19. You can go to any dentist you choose and be eligible for benefits. However, a Dental PPO network is available to help you maximize your dental care benefits.

For example, if you need a crown, let's say that the Delta Dental PPO fee allowance is $600 and the maximum allowable fee is $900. If your plan covers crowns at 70% and your dentist normally charges $1,000, your out-of-pocket cost would be:

- **Delta Dental PPO Dentist:** $180 (30% of the $600 PPO fee allowance; no balance billing);
- **Delta Dental Premier Dentist:** $270 (30% of the $900 maximum allowable fee; no balance billing); or
- **Out-of-Network Dentist:** $370 (30% of the $900 maximum allowable fee PLUS the balance due).

MAXIMUM ALLOWABLE FEE

The dental benefits provide coverage for non-preventive services based on a maximum allowable fee. When you go to a PPO dentist, you pay only the applicable copayment for the services you receive; you will not be responsible for any charges above the maximum allowable fees. If you go to a non-PPO dentist that charges more than the maximum allowable fee for a covered service, the Plan will pay benefits based on the maximum allowable fee.

Delta Dental of Illinois has set maximum allowable fees for dental procedures. The list and the fees change from time to time. Please contact Delta Dental of Illinois dental customer service department at 800-323-1743 to find out the maximum allowable fee for that procedure quoted to you or your dentist.

THE DENTAL PPO NETWORK

You can reduce your out-of-pocket costs when you receive services from a dentist who belongs to **Delta Dental of Illinois's PPO Network.** In return for our membership's business, the dentists in this network have agreed to accept the Fund's maximum allowable fees as payment in full. When you go to a PPO dentist, you pay only the applicable copayment for the services you receive; you will not be responsible for any charges above the maximum allowable fees.

You can go to a non-PPO dentist and still be eligible for benefits. However, you will be responsible for any amount in excess of the maximum allowable fee for any covered service, in addition to any copayment due. Preventive services are not subject to maximum allowable fee.

If you would like assistance in selecting a Dental PPO network dentist, call Delta Dental of Illinois at 800-323-1743 and identify yourself as a member of the Midwest Operating Engineers Retiree Welfare Fund. A list of Delta Dental PPO Dentists is also available on the Delta Dental of Illinois website at **www.deltadentalil.com** (or use the link on the Welfare Fund's website).

Dentists can go in and out of the network. Each time you make an appointment, ask your dentist if he or she is in the network.

You can go to any licensed general or specialty dentist.

You can use the Family Supplemental Benefit to help pay for dental care. See page 38 for more information about the Family Supplemental Benefit.

You will maximize your benefits by receiving care from a Delta Dental PPO or Delta Dental Premier network dentist. Delta Dental's network dentists have agreed to reduced fees as payment in full, which means you will likely save money by going to a Delta Dental PPO or Delta Dental Premier network dentist.

You are charged only the patient's share at the time of treatment. Delta Dental pays its portion directly to network dentists.

Non-network dentists have not agreed to accept our reduced fees as payment in full, which means they may bill you for any charges over our allowed fees.

If you use a non-network dentist, Delta Dental will pay you directly leaving you responsible to pay the provider.

ORTHODONTIA TREATMENT

Orthodontia benefits are available to dependent children under age 19. Orthodontic treatment basically consists of three phases: diagnosis, banding and treatment. When your child first visits an orthodontist for the purpose of braces or an orthodontic appliance, the orthodontist should submit a treatment plan to Delta Dental. The treatment plan should contain the following information:

- Estimated number of months of treatment,
- Total fee,
- Cost for initial placement of appliance (banding), and
- Monthly treatment fee.

Once the orthodontist has completed the placement of the appliance, the orthodontist should submit a claim for payment for that procedure. Claims for additional monthly fees should be submitted to Delta Dental.

If a child's eligibility under the Plan ends or if the child reaches age 19 during the course of treatment, payment of orthodontic benefits will stop.

If one of your children is having orthodontic work done when he or she first becomes eligible for benefits, the Plan will pay benefits for treatment received while the child is covered by the Plan, (provided he or she is eligible for orthodontic benefits).

LIMITATIONS

Benefits for eligible expenses are limited as follows:

- The maximum benefit payable is $1,500 per calendar year for each covered person. There is no maximum for children under age 19.
- Oral examinations, prophylaxis (routine or periodontal maintenance) are limited to two times per calendar year.
- Fluoride and sealant applications for eligible children under age 19. All these services are limited to two times per calendar year.
- Anesthesia coverage is limited to 45 minutes per procedure.
- Inlays alternated to fillings. For further consideration of extenuating circumstances, contact Delta Dental.

- Full mouth or panoramic x-rays are limited to once every 36 months, unless medically necessary.
- Bitewing x-rays are limited to two times every calendar year.
- Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of 24 consecutive months;
- Replacement of a bridge, crown or denture, but only if:
  - The replacement was installed at least five years prior to its placement; or
  - The full denture is made necessary by extraction of one or more natural teeth after the existing bridge, crown or denture was installed; or
  - The replacement is required to repair one or more natural teeth after the existing bridge or crown was installed; or
  - The bridge, crown or denture, while on the mouth, has been damaged beyond repair as the result of an injury and cannot be made serviceable;
- Orthodontic services are covered for dependent children up to the age of 19. Benefits are subject to the $2,000 lifetime maximum payment.
- Covered filling materials are limited to silver amalgam, silicate, acrylic, synthetic porcelain and composite.
- Crowns will be provided only if there is insufficient tooth structure to retain an amalgam, silicate or plastic restoration.
- Crowns and bridgework will be provided in the presence of sufficient breakdown or decay and adequate bone support.
- Benefits for general anesthesia are payable only when required due to medical necessity and if administered with a covered dental procedure by a person who is licensed to administer general anesthesia.
- Benefits will be adjusted, limited or excluded for any services, treatment or supplies payable under any group medical or dental benefit plan, which covers the eligible dependent as primary (see *Coordination of Benefits* on page 44).

EXCLUSIONS

Expenses for the following services are not covered under the Dental Benefit:

- Charges for prescribed drugs and medicines, analgesia or local anesthesia. Please note that prescription drugs related to dental treatment may be available through the prescription drug program;
- Oral cancer screening;
- Bruxism devices or mouthguards;
- Temporary or mini implants;
- General anesthesia administered in excess of 45 minutes;
- Cosmetic dentistry;
- Any replacement of a bridge, crown or denture repairable by common dental standards;
- Instructions for plaque control, oral hygiene and diet;
- Services that are covered under the medical plan;
- Treatment rendered by someone other than a licensed dentist, or licensed dental hygienist working under the supervision of a dentist;
- Charges for any procedure not completed, or any prosthetic appliance unless the appliance is actually inserted or delivered;
- Temporary and mini bridges, dentures or crowns;

- Infection control costs;
- Procedures, appliances or restorations, other than fillings, that are necessary to alter, restore or maintain occlusion with the exception of any services listed as an eligible expense. Excluded services will include, but are not limited to:
  - Increasing vertical dimension,
  - Periodontal splinting,
  - Realignment of teeth,
  - Orthognathic recordings, or
  - Replacing or stabilizing tooth structure loss by attrition;
- Any treatment or procedure (except orthodontia) that was incurred before the date the covered person's dental coverage started or after the person's coverage terminated;
- Subgingival curettage and/or root planing unless the presence of periodontal disease is confirmed by x-rays and periodontal charting of pocket depths for each tooth involved;
- Any experimental or investigational procedures or procedures that are not generally recognized by the dental profession as being appropriate for the condition being treated; or
- Charges made by a provider who is the parent, spouse, child or sibling of, or who resides with the covered person, for services they provide to the covered person. However, charges for covered services and supplies obtained from an outside vendor will be payable.

APPEALS PROCEDURES

Request for Appeal of Adverse Benefit Determination: If the member disagrees with Delta Dental of Illinois (DDIL) adverse benefit determination, he or she may appeal this determination to the Reevaluation Committee of DDIL within 180 days following receipt of the adverse benefit determination. The appeal must be in writing and must state why it is believed that DDIL's benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. The Reevaluation Committee's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Upon request, DDIL will provide, free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim.

Your appeal should be addressed as follows:

Delta Dental of Illinois
Attention Reevaluation Committee
111 Shuman Boulevard
Naperville, Illinois 60563

Reevaluation Committee's Review: The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an adverse benefit determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, the Reevaluation Committee shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the dental consultant who made the initial claim denial nor the subordinate of such consultant. The Reevaluation Committee shall provide upon request by the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

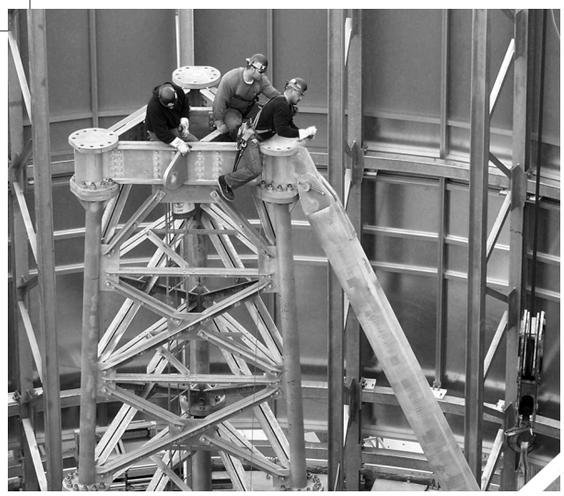
Notice of Review Decision: The Reevaluation Committee shall notify the claimant in writing of its decision on the appeal within 60 days of receipt of the request for review.

If the Reevaluation Committee upholds the adverse benefit determination on appeal, the notice to the claimant shall include the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) for the adverse determination, including specific plan provisions upon which the determination is based;
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request;
- A statement of the claimant's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), to bring a civil action under ERISA;
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse determination;
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.
- If applicable, a statement of the right to request, free of charge, a copy of the specific internal rule, guideline, protocol or similar criteria relied on to make the decision.

IF YOU HAVE QUESTIONS

If you have any questions regarding dental claims contact Delta Dental of Illinois at 800-323-1743.



FAMILY SUPPLEMENTAL BENEFIT

You and/or your eligible dependents may receive reimbursement for non-covered, medically necessary, and unreimbursed medical, dental or pharmacy expenses (that are considered deductible medical expenses by the IRS) under the Family Supplemental Benefit (FSB). There are two exceptions to this rule that are also covered under the FSB:

- Expenses that are over a Plan maximum, and
- TMJ and orthoptic training charges that are payable at 50%.

These expenses will be reimbursed up to the maximum benefit per family per calendar year as shown in the schedule of benefits. Under the Family Supplemental Benefit, there is no deductible and eligible expenses are allowed subject to the Family Supplemental Benefit maximum.

FSB EXPENSES

FSB expenses, minus applicable coinsurance, include, but are not limited to, the following:

- Eye exams and prescription eyeglasses or contact lenses,
- Hearing tests and hearing aids,
- Orthodontic expenses in excess of the lifetime orthodontia maximum,
- Routine physicals for children over the age of 2,
- Dental benefits in excess of the calendar year maximum benefit (minus any applicable coinsurance), and
- Medically necessary genetic testing.

Requests for reimbursement must be received by the Fund Office within one year (12 months) after the expense was incurred.

EXCLUSIONS

No benefits are payable for these expenses:

- Expenses which are not medically necessary;
- Deductibles;
- Copayments;
- Medications and drugs that do not require a prescription to purchase;
- Weight loss programs;
- Tobacco cessation programs;
- Exercise programs, health club dues or membership fees;
- Hot tubs or jacuzzis;
- Cosmetic treatments such as teeth bleaching kits or treatments, cosmetic surgery, facials, etc.;
- Charges that are in excess of reasonable and customary charges;
- Dental and orthodontia charges in excess of the maximum allowable fees;
- Group insurance premiums for your spouse's employer's health plan;
- School expenses, including costs related to special educational programs for problem children; or
- Expenses which are not deductible for federal income tax purposes.

For more information regarding deductible expenses for federal income tax purpose, please visit **www.irs.gov** (Publication 502).

HOW TO FILE FAMILY SUPPLEMENTAL BENEFIT CLAIMS

To file a Family Supplemental Benefit claim, you must submit a Family Supplemental Benefit Claim Form along with your itemized bill or your Explanation of Benefits (EOB) from the Fund Office that relates to the claim and your paid receipt. Your Family Supplemental Benefit claim must be received by the Fund Office within one year (12 months) of the date the expense is incurred.

Be sure to use a Family Supplemental Benefits Claim Form so that the Fund Office will recognize your claim as being submitted for the Family Supplemental Benefit.

PLEASE NOTE: If there is a Qualified Medical Child Support Order (QMCSO) on file with the Fund Office, absent proof of who paid for the services, reimbursement will be made to the retiree.

FILING FAMILY SUPPLEMENTAL BENEFIT CLAIMS FOR ORTHODONTIA SERVICES

The Welfare Fund allows for reimbursement of orthodontic expenses in excess of the lifetime orthodontia maximum under your Family Supplemental Benefit (FSB).

To get reimbursed, complete the same steps as above. In addition, you will need to include a copy of the patient's financial agreement (first reimbursement submission only) and proof of payment with your form and itemized bill/EOB.

You must wait for Delta Dental to process the initial fee for orthodontic treatment before you can submit your FSB claim.

You can be reimbursed throughout the entire time that you are in active treatment. If your treatment ends early, reimbursement will only be through the date that braces are removed.

Fees related to missed appointment or late payments; discounts (insurance or otherwise); and amounts over Reasonable and Customary (R&C) are not eligible for reimbursement from the FSB.

RETIREE MEDICAL SAVINGS PLAN

If you have a Retiree Medical Savings Plan (RMSP) account when you retire, you may use the funds accumulated in your account in a variety of ways to cover health expenses after retirement.

RETIREE SELF-PAY BENEFITS

If you retire and are eligible for this Fund's Retiree Welfare Plan Benefits, you can use the funds in your RMSP account to cover your retiree self-payment premiums.

Retiree self-pay benefits are paid in the form of transfers from your RMSP account to the Midwest Operating Engineers Retiree Welfare Plan in the amounts you are required to pay for Retiree Welfare Plan Benefits.

If and when your account has been exhausted, you can continue to make retiree self-pays to the Fund for Retiree Welfare Plan Benefits.

If you elect the retiree self-pay option, your RMSP account can also be used to pay for:

- Premiums for a tax-qualified long-term care insurance policy, or
- Tax-qualified nursing home expenses, and tax-qualified home health care and hospice care expenses, and/or
- Premiums for another qualified healthcare plan, Medicare Part A, Medicare Part B, a Medicare Advantage Plan, a Medicare Part D (prescription drug) Plan, or a Medicare Supplement ("Medigap") Plan.

SUPPLEMENTAL MEDICAL BENEFITS

If you are not eligible for this Fund's Retiree Welfare Plan Benefits, or do not elect that coverage, you can use your RMSP funds to pay for:

- Premiums for another group health care plan,
- Your deductibles and copayments under another group health care plan,
- Premiums for Medicare Part A, Medicare Part B, a Medicare Advantage Plan, a Medicare Part D (prescription drug) plan or a Medicare supplement ("Medigap"),
- Premiums for a tax-qualified long-term care insurance policy, or
- Tax-qualified nursing home expenses, and tax-qualified home health care and hospice care expenses.

NON-REIMBURSABLE EXPENSES

Your RMSP account may only be used to make self-payments or for the types of expenses listed on the previous page. Your account may not be used to pay for:

- Life insurance policies,
- Loss-of-earnings policies,
- Accidental death and loss of limb, sight, etc. policies,
- Daily indemnity policies that pay you a specified amount while you are hospitalized,
- Med pay coverage under your vehicle insurance, or
- Any taxes imposed by any governmental body.

RMSP BENEFITS FOR YOUR BENEFICIARY

If you die, any remaining RMSP benefits will be transferred to your named beneficiary for continued health care coverage under the Fund. If the surviving beneficiary happens to be an Active member, he or she may use your RMSP account balance while covered under the Active plan. If there is no named beneficiary, your RMSP will transfer to your surviving spouse. If there is no surviving spouse, your RMSP will transfer to your Eligible Dependents, equally if more than one, or if none, the balance in his Individual Account will be forfeited.

For purposes of the RMSP, "eligible dependents" include your spouse, child (natural born, stepchild or adopted) or children for whom you are legal guardian.

If your RMSP is transferred to your surviving spouse and your surviving spouse dies:

- Your RMSP account will transfer to your contingent beneficiaries; or if none
- Your RMSP account will be transferred in equal portions amongst all of your surviving children.

RMSP BENEFITS FOR MOE RETIREES NOT ELIGIBLE FOR MOE RETIREMENT BENEFITS

MOE Retirees who are not eligible for retiree benefits may use RMSP benefits if they are in retirement status from another employer with valid documentation.

HOW TO USE YOUR RMSP ACCOUNT

INITIAL APPLICATION

A form completed and signed by you that provides your identification information, including but not limited to address and date of birth, and authorizes the Administrative Manager to use your Individual RMSP Account for Retiree Self-Pay or Supplemental Medical Benefits.

RMSP ACCOUNT CLAIMS

Claims for payment of RMSP Benefits must be filed in accordance with the Fund's normal claim procedures and time limits. To file an RMSP Benefit claim, you must submit your RMSP Benefit Claim Form along with your itemized bill or your Explanation of Benefits (EOB) from the Fund Office that relates to the claim and your paid receipt. Your RMSP Benefit claim must be received by the Fund Office within one year (12 months) of the date the expense is incurred.

If you do not use an RMSP Benefit Claim Form, the Fund Office may not recognize your claim as being submitted for the RMSP Benefit. This may result in your claim payment being delayed or denied.

GENERAL EXCLUSIONS

The following are some general Plan exclusions that apply to all Plan benefits. Other exclusions are listed in the specific benefit sections of this book. For example, the exclusions that apply to medical benefits start on page 25.

- Charges that are above the reasonable and customary limits (for non-PPO medical provider services) and/or negotiated fees (for PPO medical and dental provider services), and/or the Medicare-approved amounts (for Medicare-eligible participants);
- Services or supplies that are not considered medically necessary;
- Experimental or investigational services or supplies;
- Services or supplies that are not prescribed by a licensed physician or eligible provider licensed to prescribe that service or supply;
- Services or supplies that are not performed by an eligible provider under the Plan;
- An illness or injury that is covered under Workers' Compensation, or that is recoverable from a responsible third party;
- Expenses for which you had a right to payment under Tricare or Medicare;
- An illness or injury resulting from war or any act of war, or from the commission of a felony, except as the result of an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Illness or injury for anyone who is currently serving in the armed forces and covered under Tricare;
- Custodial or maintenance care;
- Complications from non-covered procedures;
- Food supplements;
- Braces, trusses and foot orthotics that can be purchased over the counter; or supplies such as bandages, gauze, tape, syringes and needles (unless provided and used while in the hospital);
- Tobacco cessation products or programs;
- Speech or occupational therapy, except as specifically provided under the Plan;
- Vision or hearing exams, except for treatment of accidental injuries;
- Orthodontic services and supplies, except as specifically provided for under the Plan;
- Personal convenience items such as telephone, television, cot rental, guest meals, travel, copying of medical records or fees to complete a claim form;
- Charges by a provider who is the parent, spouse, child or sibling of, or resides with the covered person;
  - Services provided by a parent, spouse, child, brother or sister of you or your eligible dependent will be reimbursed for the amount that would otherwise be billed for the service, but not to exceed the reasonable and customary charge that would be made to a non-relative provider. The Plan will also reimburse a relative who provides dental care for the cost of supplies purchased from other vendors, up to the vendor's invoice amount, but not to exceed the reasonable and customary charge that would be made to a non-relative provider;
- Expenses incurred outside of the U.S. except for an accident or an unforeseen and acute medical emergency; and while on work assignment, vacation (of 30 days or less) or as a full-time student participating in a school-sponsored program;
- Chelation therapy, except in cases of heavy metal poisoning;

- Charges for prenatal services, maternity services and prescription drugs related to a pregnancy incurred by a covered retiree or covered dependent acting as a surrogate mother (gestational carrier);
- Shoes, shoe modifications or shoe lifts, except as otherwise allowed under the Plan;
- Any services or supplies for which:
  - No charge is made,
  - The individual is not legally required to pay, or
  - The Fund is not legally required to pay.

If you have a specific question that is not addressed above, contact the Fund Office.

OTHER PROVISIONS THAT CAN LIMIT BENEFITS

COORDINATION OF BENEFITS

Your Plan contains a coordination of benefits provision. This provision provides that if you are covered under more than one group plan, benefits may be payable under both plans, and establishes the priority for payment.

Coordination of benefits applies to all benefits payable by this Plan except for prescription drug program benefits.

If you have a claim that is covered by two or more group plans, one plan, called the primary plan, pays its benefits first. The other plan, called the secondary plan, adjusts its benefits so that the total benefits paid on your behalf are not greater than the eligible expense. *No plan pays more than it would without the coordination of benefits provision*. In no event will the total benefits paid from both plans exceed 100% of the allowable expenses. An allowable expense is any medically necessary, reasonable and customary expense for care or treatment performed by a licensed provider that is covered under at least one of the plans. When benefits are reduced by the primary plan because you did not comply with the plan's provisions, such as the provisions related to case management or use of certain providers under a PPO, EPO or HMO plan, the amount of those reductions will not be considered an allowable expense by this Plan when it pays secondary, except when related to services from ATI. Allowable expenses include both assigned and non-assigned expenses. If either plan has a contract with the provider, including under a PPO, EPO or HMO agreement, the combined payments of both plans will not be more than what the contracted plan's contract calls for. If the patient's primary plan reduces benefits otherwise payable as a result of non-compliance with the primary plan's specific provisions, the amount of that reduction is not considered in determining the allowable expense by this Plan.

If you have an individual medical policy, the coordination of benefits rules do not apply.

A plan without a coordination of benefits provision is always considered the primary plan. If all plans have a coordination of benefits provision, the first to apply of the following rules will be used to determine which plan is primary and which is secondary:

- Medicare is primary over a plan that covers the patient as a retiree.
- The plan that covers a patient as an employee is primary over a plan that covers the patient as a retiree.
- The plan that covers a patient as an employee is primary over a plan that covers the patient as a dependent.
- A plan, which covers a person other than as a dependent, shall pay its benefits before a plan, which covers the person as a dependent.
- For claims on behalf of children who are covered under both parents' plans and the parents are not separated or divorced, whether or not they were ever married, then plan of the parent whose birthday comes earlier in the calendar year is the primary plan. If both parents have the same birthday, the plan covering the parent for the longer period of time is primary. (However, if one plan uses a male/female rule and the other plan coordinates using the birthday rule, the plan using the male/female rule will pay its benefits first.)
- In the event a father and mother are separated or divorced, whether or not they were ever married, the plan that covers the child as a dependent of the parent with financial responsibility for the child's medical expenses by virtue of a court decree will pay first. If there is no such court decree establishing this financial responsibility, then the payment order is:
  - The plan that covers the parent with custody pays before the plan that covers the parent without custody.
  - If the parent has remarried, the plan that covers the stepparent with custody pays before the plan that covers the parent with custody.

If none of the above establishes the primary plan, the plan which has covered the person for the longer continuous period of time will pay the benefit before the plan which has covered the person for the shorter period of time.

On coordinated claims, the Fund Office must be provided with a fully completed claim form, itemized bills and the matching payment explanation or denial showing the other plan's decision.

COORDINATION WITH HEALTH MAINTENANCE ORGANIZATIONS OR DENTAL MAINTENANCE ORGANIZATIONS

In order for any expense to be considered under this Plan, you must have complied with all the requirements of the HMO or DMO for coverage of the expense under the HMO's or DMO's rules. For example, if your wife is covered by an HMO and receives treatment from a non-HMO physician (to which she was not referred by the primary HMO doctor), the HMO will deny benefits. No benefits would be payable for the treatment under this Plan, since she did not follow the HMO rules. It is very important for your eligible dependents to comply with the HMO's or DMO's rules.

BENEFIT CREDIT AMOUNT

Any benefit savings resulting from coordination of medical benefits during the calendar year will be held in your or your eligible dependent's benefit credit account for payment of covered expenses on your or your dependent's future medical claims incurred during that calendar year.

COORDINATION WITH MEDICARE

At age 65, you normally become eligible for Medicare.

If you are covered by both Medicare and this Plan, then Medicare eligibility also extends to disabled individuals and those with certain conditions. For example, Medicare covers certain expenses for kidney dialysis. If you have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) and you are in the first 30 months of eligibility and enrollment in Medicare, the Plan is primary and Medicare is secondary. After 30 months of eligibility or entitlement to Medicare, Medicare is primary and the Plan is secondary.

When Medicare is primary, the Plan's benefits will be reduced so that the combination of benefits paid by Medicare and the Plan do not exceed the amount that the Plan would have paid without Medicare. If you use a non-Medicare provider when Medicare must be primary, any amounts not paid by Medicare as a result of the failure to use a Medicare provider or to otherwise follow Medicare's rules will not be considered an Allowable Expense by this Plan as secondary payor. If you are covered under a Medicare Part C plan, no benefits shall be payable by this Plan.

PLEASE NOTE: Remember, if you are eligible for Medicare, these Coordination of Benefits rules are applied as if you are eligible for both Part A and Part B coverages under Medicare, even if you do not elect to take Part B coverage. Therefore, it is important for you to maintain both Part A and Part B coverage under Medicare. If you do not enroll in Part A and Part B, the benefits provided under this Plan will be paid as if you were enrolled in Part A and Part B; leaving you responsible for any balance due. If you enroll for Medicare prescription drug coverage (Medicare Part D) no prescription drug benefits will be paid by this Plan. Your other Fund benefits will **not** be affected.

If you are enrolled in a Medicare supplemental insurance (Medigap) plan, this Plan shall coordinate its benefits so that the sum of this Plan's benefits and the other Plan's benefits, or the reasonable cash value of the managed care plan's benefits, shall not exceed the Allowable Expenses for the services.

MEDICARE CROSSOVER

Your Medicare claims are submitted directly from Medicare to the Fund Office. This means, you will only need to complete one claim submission. DO NOT submit a health care claim to both Medicare and the Fund Office—duplicate claims result in possibly inaccurate claims processing and delays.

If you must submit a claim, submit it to your Medicare provider when Medicare is considered primary and the Retiree Welfare Plan is secondary.

When you receive the remittance from Medicare, check to make sure the claim was automatically forwarded to the Fund Office—you should see remark codes MA18 or N89 if the claim was forwarded. If you see the correct remark codes, you do not need to resubmit that claim to the Fund Office. If the remittance indicates that the claim was not crossed over, submit the claim to the Fund Office with the Medicare remittance attached.

COORDINATION WITH A WRAPAROUND PLAN OR SUB-PLAN

If another plan contains a provision stating that the benefits payable under that plan (sometimes called a "wraparound plan" or "sub-plan") are reduced because of, or by reason of, benefits payable under this Plan, any and all benefits payable under this Plan for such a claim will be payable as if the other plan's benefits had not been reduced and had been paid without regard to such reduction.

THIRD PARTY RECOVERY REIMBURSEMENT (SUBROGATION)

The Trustees will pay for covered services related to a work-related illness or injury. The Trustees have the right to subrogate any right you have to compensation from the offending party, to the extent of benefits paid, or to be paid. Future benefits are not payable unless the Trustees have received a completed and fully executed subrogation document.

It is your job to notify the Trustees of any claim or demand you may have against another party in connection to Plan benefits. If you recover anything from the offending party, the Trustees are entitled to immediate reimbursement to the extent of benefits paid, with or without filing a lien. This right to immediate reimbursement is subject to a pro rata deduction for any reasonable legal fees and expenses, if any, as authorized by the Trustees.

The Retiree Welfare Fund will not reimburse any work-related illness or injury expense subject to subrogation for a period of two years after the related Settlement Agreement is fully executed, judgment is entered or the matter is otherwise resolved.

The Trustees have the right to require you to repay any excess payments you may have received, including payments from a group plan with which this Plan has coordinated benefits. The Trustees also have the right to deduct such excess payments from future benefits.

CLAIMS AND APPEALS

This section describes the procedures for filing claims for benefits from the Plan. It also describes the procedures for you to follow if your claim is denied, in whole or in part, and you wish to appeal the decision.

CLAIM FILING PROCEDURES

In order for the Plan to pay benefits, you must file a claim with the Administrative Manager (or the office designated for handling the claim) in accordance with Plan procedures. A claim can be filed by you, your dependent or by someone authorized to act on behalf of you or your dependent.

A claim is considered to have been filed on the date it is received at the correct claims office, even if the claim is incomplete.

A "claim" is a request for Plan benefits made by you or your covered dependents, or your authorized representative or your covered dependent's authorized representative, in accordance with the Plan's reasonable claims procedures.

You must file a claim within one year (12 months) after the expense was incurred. It is your responsibility to see that claims and medical bills are submitted promptly and no later than the time period permitted. If the Fund Office requests additional information from you or your provider in order to process a claim, the requested information must be provided within the time period specified on the written request, or within one year from the date of service, whichever is later.

Claims must:

- Be written or electronically submitted in accordance with the Electronic Data Interchange standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Oral communication is acceptable only for urgent care claims;
- Be received by the claims office within one year of the date the claim was incurred;
- Include your and the patient's (if different) full names, Social Security numbers and/or medical I.D. numbers, and the specific medical condition or symptom;
- Be itemized by date of service, amount charged and the specific type of service provided;
- Identify the provider by name, address, telephone number, professional degree or license and federal tax identification number; and
- For pre-service claims, in addition to the information above, all pertinent medical information concerning your medical condition and the proposed treatment, including, but not limited to, the following:
  - Medical history and physical;
  - Progress notes;
  - Medical records;
  - Laboratory results and pathology reports;
  - X-rays and radiologists' reports; and
  - Operative reports and anesthesia reports.

When another plan or Medicare is primary, include a copy of the other plan's Explanation of Benefits (EOB).

You are entitled to receive upon written request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to your claim for benefits.

LANGUAGE ASSISTANCE DISCLOSURE

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

MEDICAL CLAIMS INCURRED BY MEDICARE-ELIGIBLE PARTICIPANTS

Claims incurred by retirees and dependents who are eligible for Medicare should first be filed with Medicare. See page 45 for information on Medicare crossover.

DENTAL CLAIMS

Delta Dental PPO providers will automatically submit their claims to Delta Dental. If you use a non-network dentist you may have to file your own claim. The claims mailing address is:

Delta Dental of Illinois
P.O. Box 5402
Lisle, Illinois 60532

FAILURE TO FILE A CLAIM

A request is not a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or the authorized representative of you or your covered dependent;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and you will be notified of the decision and allowed to file an appeal; or
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the claims office will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

You may designate another person at least 18 years old as your authorized representative for the purposes of filing a claim. Except in the case of an urgent care claim, such designations must be in writing from you, the claimant, (unless the claimant is a child) and include the representative's name, address and telephone number. If you are unable to provide a written statement, the Plan requires written proof such as a legal power of attorney for health care purposes, or a court order of guardianship or conservatorship showing that the representative has been authorized to act on your behalf. The designation will be valid for one year, or as mandated by a court order. You may revoke a designated authorized representative at any time by submitting a written statement. The Trustees, or their designated representative, have the sole discretion to determine whether you have properly designated an authorized representative. The Plan reserves the right to withhold information from a person who claims to be the authorized representative if there is suspicion about the qualifications of the individual claiming to be the authorized representative.

Unless the authorization states otherwise, all notices regarding the claim will then be sent to the authorized representative and not to you.

A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as an authorized representative.

CLAIMS PROCESSING

GENERAL

This section describes the procedures for making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health, substance abuse, dental, hearing, wellness and prescription drug benefits.

The Plan's internal claims and appeal procedures are designed to provide a full and fair claim review and so that Plan provisions are applied consistently with respect to you and all similarly situated covered retirees and dependents. In addition, the Plan will consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not medically necessary or appropriate, or is experimental or investigational).

The internal claims process pertains to determinations made by the claims office about whether a request for benefits (known as an initial "claim") is payable. If the claims office denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

DEFINITIONS

Term	Definition
Adverse Benefit Determination	An adverse benefit determination, for the purpose of the internal claims and appeal process, means: • A denial, reduction or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit; • A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not medically necessary or appropriate, or experimental or investigational, or • A rescission of coverage, whether or not there is an adverse effect on any particular benefit.
Authorized Representative	An authorized representative is someone who has been designated to represent a claimant for the purpose of filing and/or appealing a claim. Except in the case of an urgent care claim, the claimant's designation of an authorized representative must be in writing on a form provided by the Plan. An assignment of benefits is not such a designation. If the claimant is unable to complete the Plan's written statement, the Plan requires written proof such as a legal power of attorney for health care purposes, or a court order of guardianship or conservatorship showing that the representative has been authorized to act on the claimant's behalf. The claimant may revoke a designated authorized representative at any time by submitting a written statement. The Trustees, or their designated representative, have the sole discretion to determine whether the claimant has properly designated an authorized representative. If another person claims to be representing the claimant in his or her appeal, the Review Panel has the right to require that the claimant give the Plan a signed statement, advising the Review Panel that he or she has authorized that person to act on his or her behalf regarding his or her appeal. Any representation by another person will be at the claimant's expense. The Plan reserves the right to withhold information from a person who claims to be the authorized representative if there is suspicion about the qualifications of the individual claiming to be the authorized representative.
Claim	A claim is a request for Plan benefits, normally because the claimant has incurred a health care expense.
Claimant	A claimant is the person who has incurred the claim, except that if the claim is incurred by a dependent child, then the adult who files the claim on behalf of the child is the claimant.
Concurrent Claim	A concurrent claim is a pre-service claim where a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved.
Days	For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.
Health Care Professional	A health care professional, for the purposes of the claims and appeals provisions, means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.
Pre-Service Claim	A pre-service claim is a request for authorization of a type of treatment or supply that requires approval in advance of obtaining the care. A request for confirmation of Plan coverage is not a claim if the expense has not yet been incurred, unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy.
Urgent Care Claim	An urgent care claim is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize the claimant's life, health, or ability to regain maximum function, or that could subject the claimant to severe pain that cannot be adequately managed without the proposed treatment.

DISCRETIONARY AUTHORITY OF ADMINISTRATIVE MANAGER AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Administrative Manager, other Plan fiduciaries and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

TYPES OF CLAIMS

Health Benefit Claims	Health benefit claims can be filed for medical, mental health, substance abuse, dental, vision, wellness and prescription drug benefits. There are four categories of health claims.
Pre-Service Claims (applicable to medical, mental health, substance abuse and prescription drug benefits)	A pre-service claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for certain medical, mental health, substance abuse and prescription drug benefits.
Urgent Care Claims (applicable to medical, mental health, substance abuse and prescription drug benefits)	An urgent care claim is any pre-service claim for health care treatment that (i) could seriously jeopardize your life or health or your ability to regain maximum function, or (ii) in the opinion of your attending health care provider with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for you to obtain the pre-approval, or the pre-approval process would jeopardize your life or health.
Concurrent Claims (applicable to medical, mental health, substance abuse and prescription drug benefits)	A concurrent claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a concurrent claim can pertain to a request for an extension of a previously approved treatment or service.
Post-Service Claims (applicable to medical, mental health, substance abuse, dental, vision, wellness and prescription drug benefits)	A post-service claim is a request for benefits under the Plan that is not a pre-service claim. Post-service claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A claim regarding the rescission of coverage will be considered to be a post-service claim.

INITIAL CLAIM DECISION TIMEFRAMES

Health Benefit Claims	The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
Pre-Service Claims (applicable to medical, mental health, substance abuse and prescription drug benefits)	Claims for pre-service (that are not for urgent care) will be decided no later than 15 days after receipt by the claims office. You will be notified in writing (or electronically, as applicable) within the initial 15-day period whether the claim was approved or denied (in whole or in part).

Pre-Service Claims *continued*	The time for deciding the claim may be extended by up to 15 days due to circumstances beyond the claims office's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if applicable) notification before the expiration of the initial 15-day determination period. If you improperly file a pre-service claim, the claims office will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five days after receiving the claim. The notice will describe the proper procedures for filing a pre-service claim. Thereafter, you must re-file a claim to begin the pre-service claim determination process. If a claim cannot be processed due to insufficient information, the claims office will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial 15-day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the claims office receives your response to the request for information. The claims office then has 15 days to make a decision and notify you in writing (or electronically, as applicable).
Urgent Care Claims (applicable to medical, mental health, substance abuse and prescription drug benefits)	In the case of an urgent care claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an urgent care claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form. The claims office will decide claims for urgent care as soon as possible, but in no event later than 72 hours after receipt of the claim. The claims office will orally communicate its decision telephonically to you and your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three days after the oral notification. If you improperly file an urgent care claim, the claims office will notify you and your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an urgent care claim. Thereafter, you must re-file a claim to begin the urgent care claim determination process. If a claim cannot be processed due to insufficient information, the claims office will provide you and your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you and your health care professional no later than 48 hours after the claims office receives the specific information or the end of the period given for you to provide this information, whichever is earlier.
Concurrent Claims (applicable to medical, mental health, substance abuse and prescription drug benefits)	If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated. A concurrent claim that is an urgent care claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the urgent care claim section. A concurrent claim that is not an urgent care claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the pre-service or post-service claim, as applicable, provisions described above in this section. If the concurrent care claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three calendar days after the oral notice. If the concurrent care claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

Post-Service Claims (applicable to medical, mental health, substance abuse, dental, vision, wellness and prescription drug benefits)	Claims for post-service treatments or services will be decided no later than 30 days after receipt by the claims office. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part). The time for deciding the claim may be extended by 15 days due to circumstances beyond the claims office's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period. If a claim cannot be processed due to insufficient information, the claims office will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after the receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the claims office receives your written response to the request for information. The claims office then has 15 days to make a decision and notify you in writing (or electronically, as applicable).

INITIAL DETERMINATIONS OF BENEFIT CLAIMS

Notice of adverse benefit determination. If the claims office denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Give the specific reason(s) for the denial;
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide an explanation of the Plan's internal appeal and external review processes along with time limits and information about how to initiate an appeal and an external review;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;
- If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request; and
- For urgent care claims, the notice will describe the expedited internal appeal and external review processes applicable to urgent care claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification.

Notice of approval of pre-service and urgent care claims. If a pre-service claim is approved, you will receive written (or electronic, as applicable) notice within 15 days of the claims office's receipt of the claim. Notice of approval of an urgent care claim will be provided in writing (or electronically, as applicable) to you and your health care professional within the applicable timeframe after the claims office's receipt of the claim.

CLAIM APPEAL PROCEDURES

If a claim has been denied, in whole or in part, you may request a full and fair review (also called an "appeal") in accordance with Plan procedure.

A notice of appeal must be submitted within 180 days after you receive the written notice of denial of the claim. The appeal is considered to have been filed on the date the written notice of appeal is received by the claims office.

The Review Panel will be the Board of Trustees or a committee of the Board of Trustees. The Review Panel will not include the person, or a subordinate of the person, who made the original claim denial.

The Plan has a two-level process for pre-service and post-service health care claims appeals submitted to the Review Panel.

- The initial written appeal must be submitted to the Fund Office, except in the case of an urgent care or pre-service claim appeal that may be presented verbally.
- If the initial appeal is denied, you may submit a second-level appeal of a pre-service or post-service health care claim to the Review Panel at the address of the Administrative Manager. Second-level appeals must be submitted within 30 days of the date of the notice that the initial appeal was denied.

You may designate an authorized representative as described above to represent you in connection with an appeal. Except in the case of an urgent care claim, your designation of an authorized representative must be in writing on a form provided by the Plan. An assignment of benefits is not such a designation. If you are unable to complete the Plan's written statement, the Plan requires written proof such as a legal power of attorney for health care purposes, or a court order of guardianship or conservatorship showing that the representative has been authorized to act on your behalf. If another person claims to be representing you in your appeal, the Review Panel has the right to require that you give the Plan a signed statement, advising the Review Panel that you have authorized that person to act on your behalf regarding your appeal. Any representation by another person will be at your expense.

Appeals may only be initiated by the eligible member or his or her spouse or your authorized representative who has been designated in accordance with the Plan provisions as described above. Appeals will not be accepted from other persons or entities, including providers who are not duly designated authorized representatives.

You (and your authorized representative, if any) may request to appear in person before the Review Panel. If the Trustees grant your request, you and your representative's appearance must be at your expense. Any hearing before the Review Panel to which you or your representative is invited will be conducted in an informal manner, and no Review Panel proceeding will be recorded, electronically or stenographically.

You or your authorized representative may review pertinent documents and may submit comments and relevant information in writing. Upon written request, the Administrative Manager will provide reasonable access to, and copies of, all documents, records or other information relevant to the claim. The Administrative Manager will not charge for copies of documents requested by you in connection with an appeal.

If the claims office obtained an opinion from a medical or vocational expert in connection with the claim, the Administrative Manager will, on written request, provide you with the name of that expert.

In deciding the appeal, the Review Panel will consider all comments and documents that are submitted, regardless of whether that information was available at the time of the original claim denial. The review will not defer to the initial denial, and will take into account all comments, documents, records and other information submitted, without regard to whether such information was previously submitted or relied upon in the initial determination.

If an appeal involves a medical judgment, such as whether treatment is medically necessary, the Review Panel will consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the Review Panel will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal. If the appeal is for an urgent care claim, you will be notified of the decision about the appeal as soon as possible, taking into account the circumstances, but not later than 72 hours after receipt of the request for review. In the case of non-urgent pre-service claims, you will be notified no later than 30 days after receipt of the request for review. If the appeal is for a concurrent care claim, you will be notified of the decision about the appeal as soon as possible before the benefit is reduced or treatment is terminated.

A review and determination for post-service claims will be made no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review, unless special circumstances exist requiring an extension of time, in which event the decision will be rendered not later than 120 days from the date of receipt of the written request for Review by the Administrative Manager. You will be informed of the Trustees' decision, normally within five calendar days of the review.

Claim appeal decisions will be in writing unless the appeal was for an urgent care claim and you were advised by telephone, fax, or e-mail. When you receive the written decision, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, and a statement of your right to bring an action under Section 502(a) of ERISA. If applicable, you will also be informed of your right to receive free of charge upon request the specific internal rule, guideline, protocol or similar criterion relied on to make the decision. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.

While the Plan may not automatically extend the time period for an appeal determination, the time may be extended if you agree in advance to an extension.

If the Fund fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, you may go to court to enforce your rights. You may not file suit against the Fund until you have exhausted all of the procedures described in these procedures.

GENERAL PLAN PROVISIONS

PRIVACY OF AN INDIVIDUAL'S HEALTH INFORMATION

The Midwest Operating Engineers Retiree Welfare Fund will use and disclose protected health information (individually identifiable health information, regardless of the form in which it is kept) only to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. The Fund will not disclose protected health information to the Plan Sponsor, the Board of Trustees, or permit a health insurance issuer or HMO to disclose protected health information, unless this disclosure complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. The Fund further complies with HIPAA by providing to individuals covered by the Plan, in accordance with HIPAA and its Regulations, a Notice of Privacy Practices detailing the Fund's practices regarding protected health information.

TRUSTEE INTERPRETATION AND AUTHORITY; DECISIONS REGARDING BENEFITS

The Trustees or persons acting for them, such as a claims review panel, have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Right to Modify the Plan

The Trustees reserve the right to change, modify or discontinue all or part of this Plan at any time.

All benefits under the Plan are subject to the Trustees' authority to change them. The Trustees have the authority to increase, decrease, change, amend, or terminate benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of the Plan's covered eligible retirees and beneficiaries.

Benefits under this Plan will be paid only when the Board of Trustees or persons delegated by them decide, in their sole discretion, that you or your beneficiary is entitled to benefits.

The Plan is maintained for the exclusive benefit of the Plan's covered eligible retirees and their dependents. All rights and benefits granted to a participant under the Plan are legally enforceable.

PLAN DISCONTINUATION OR TERMINATION

This Plan may be discontinued or terminated. In such event, benefits for covered charges incurred before the termination date will be paid on behalf of eligible family members as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the funds available in the trust fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy, including lymphedema.

Plan limits, deductibles, copayments and coinsurance apply to these benefits. For more information on WHCRA benefits contact the Fund Office at 708-579-6600.

COVERAGE FOR MATERNITY HOSPITAL STAY

Under federal law, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

RIGHT TO RECOVER OVERPAYMENTS

The Fund has the right to recover any overpayments made under the Plan, regardless of why the overpayment was made. Recovery can be made from any persons (including family members), insurance companies or any other organizations.

YOUR ERISA STATEMENT OF RIGHTS

As an eligible member or dependent in the Welfare Plan of the Midwest Operating Engineers Retiree Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered eligible retirees and dependents will be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Administrative Manager's office, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Administrative Manager, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrative Manager may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each participant with a copy of this summary annual report.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $149 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Administrative Manager. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at Toll-Free: 866-444-3272.

DEFINITIONS

The following are definitions of specific terms and words used in this book.

Term	Definition
Administrative Manager	The person, firm or corporation employed by the Trustees, charged with recordkeeping, reporting and disclosure, processing of applications for benefits and related functions attendant to the administration of the Plan. (The business office of the Administrative Manager is referred to as the Fund Office.)
Affordable Care Act (ACA)	The Patient Protection and Affordable Care Act, Public Law No. 111-48, as modified subsequently enacted Health Care and Education Reconciliation Act, Public Law 111-152.
Case Manager	A utilization management company operating under a contract with the Plan that determines, subject to the final decision of the Trustees, what services and supplies are medically necessary, and the appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during, or after the services are rendered and may include, but is not limited to: • Certification and/or authorization; • Concurrent and/or continued stay review; • Discharge planning; • Retrospective review; • Case management; • Hospital, physician, or other health care provider bill audits; and • Provider fee negotiation.
Contributing Employer	A contributing employer is any of the following: • An individual, partnership, or similar business entity, firm or corporation, which is an employer under ERISA that is bound to make contributions to the Fund, under the provisions of a written: – Collective bargaining agreement entered into with the Union by an association on behalf of its members, or as the collective bargaining representative of such individual partnership or similar business entity, firm or corporation on behalf of employees within the bargaining unit covered by such collective bargaining agreement; – Collective bargaining agreement entered into separately with the Union on behalf of employees within the bargaining unit covered by such collective bargaining agreement; or – Participation agreement entered into with the Board of Trustees, at their discretion. However, if the contributing employer is making contributions on behalf of non-bargaining unit employees, and stops participating for any period of time, the contributing employer may not ever again contribute on behalf of non-bargaining unit employees. • An association, which enters into a written agreement with the Union, under which it is bound to make employer contributions to the Fund on behalf of its employees included within the definition of employee. • The Trustees of any of the following: – The Midwest Operating Engineers Pension Fund; – The Midwest Operating Engineers Retiree Welfare Fund; – The Operating Engineers Local 150 Apprenticeship Fund; – The Local 150, I.U.O.E. Vacation Savings Plan, prior to December 31, 2017; – The Midwest Operating Engineers Retirement Enhancement Fund;

Term	Definition
Contributing Employer *continued*	– The Midwest Operating Engineers Construction Industry Research Service Trust Fund; and – The Midwest Operating Engineers Information Technology Services Corporation; who enter into a written agreement with the Union, under which they are bound to make contributions to the Fund on behalf of their employees within the definition of employee; or • The Union, upon its written declaration delivered to the Trustees, under which the Union is bound to make contributions to the Fund on behalf of its employees within the definition of an employee.
Compounded Drugs	A compounded drug is a pharmaceutical product that results from the combining, mixing or altering of two or more ingredients, excluding flavorings, to create a customized medication for an individual patient in response to a licensed practitioner's prescription. (This is a drug that has more than one ingredient. At least one of the ingredients has to be a federal Legend Drug or a drug, which requires a prescription under state law. A minimum of one ingredient must be must be covered through the Plan.)
Copayment	The portion of the covered expense, which is required to be paid by you and is not subject to reimbursement by the Plan.
Cosmetic Surgery or Treatment	Surgery or treatment that is performed primarily to change the appearance or improve the self-esteem of a person rather than to enhance the function or usefulness of a part of the body.
Covered Expense	With respect to all Plan benefits: • A covered expense will not exceed the reasonable and customary charge, as determined by the Administrative Manager; and • An expense must also be allowable and not excluded from coverage under the benefit provisions of the Plan in order to be considered a covered expense. With respect to the comprehensive medical benefits, the charges for reasonably necessary services and supplies for the diagnosis or care of an illness or injury. To be reasonably necessary, the service or supply must be ordered by a physician and must be recognized throughout the health care profession as the customary treatment for illness or injury.
Credit Bank	The notional account to which months of credit are recorded for active eligible members in the MOE Health Plan Marketplace.
Credits	The term used to track the employer contributions deposited into your Credit Bank. The Credits you receive are based on the number of hours you work and your negotiated hourly contribution rate minus the retiree subsidy.
Custodial Care	Services and supplies that meet one of the following conditions: • Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment. • Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

Term	Definition
Custodial Care *continued*	Care that meets one of the conditions on the previous page is custodial care regardless of any of the following: • Who recommends, provides, or directs the care; • Where the care is provided; or • Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
Eligible Dependent	Any or all of the following individuals: • The eligible member's lawful spouse, other than a spouse separated by a decree of a court of competent jurisdiction; • Those children of the eligible member who have not reached the last day of the month of their 26th birthday. For this purpose, "children" will include: – Natural children; – Stepchildren. Stepchildren are the natural or adopted children of an eligible member's spouse; – Legally adopted children or those for whom adoption proceedings have been started and the children are placed in the eligible member's home by a licensed placement agency for the purpose of adoption; and – Children for whom the Plan is required by a Qualified Medical Child Support Order (QMCSO) to consider eligible dependents. The following procedures apply to QMCSOs: » If a copy of a proposed Medical Child Support Order as defined in ERISA Section 609(a) is filed with the Administrative Manager, the Administrative Manager will promptly notify the eligible member and each alternate recipient of the receipt of such order and the Plan's procedures for determining whether the order is a Qualified Medical Child Support Order (QMCSO), as further defined in ERISA Section 609(a). » The Administrative Manager will then determine whether the order is a QMCSO pursuant to the Plan's procedures, and notify the eligible member and each alternate recipient of the determination. » The Plan will provide benefits in accordance with the applicable requirements of any QMCSO. The QMCSO will not require any type or form of benefit or any option not otherwise provided under this Plan. » Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian will be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian. • Those children of the eligible member who have reached the last day of the month of their 26th birthday but are unmarried and incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided: – Such incapacity commenced prior to age 26; and – Such children are chiefly dependent upon the eligible member for financial support and maintenance; and

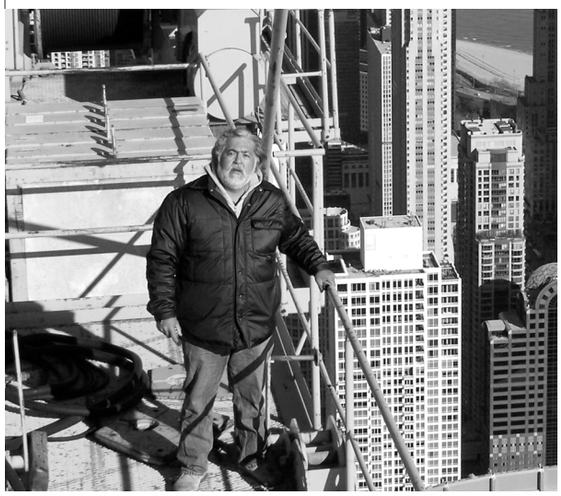
Term	Definition
Eligible Dependent *continued*	– The eligible member submits satisfactory proof of such incapacity within 31 days after the child reaches age 26. The Trustees may require, at reasonable intervals following the date the dependent reaches the age limit, subsequent proof of continuing incapacity and dependency. The Trustees reserve the right to have such dependent examined by a physician of their choice to determine the existence of such incapacity. "Mental retardation" means significantly sub-average, general intellectual functioning which exists concurrently with impairment in adaptive behavior.
Eligible Member	An employee or member is any of the following: • Bargaining unit employee – A person who is a member of the bargaining unit and who is actively employed by a contributing employer on whose behalf payments are required to be made to the Fund; or – A person employed by a Contributing Employer as a "Supervisor" as such term is defined in the Labor Management Relations Act of 1947, as amended and covered under the applicable collective bargaining agreement. • Non-bargaining unit employee. A person who is not a member of the bargaining unit but who is permitted to participate in this Plan under the terms of a participation agreement between the Trustees and the employee's contributing employer who is party to a collective bargaining agreement with the Union. • The Trustees of any of the following are eligible for Retiree Welfare Plan benefits: – The Midwest Operating Engineers Pension Fund; – The Midwest Operating Engineers Welfare Fund; – The Midwest Operating Engineers Retiree Welfare Plan; – The Operating Engineers Local 150 Retiree Welfare Plan; – The Local 150, I.U.O.E. Vacation Savings Plan prior to December 31, 2017; – The Midwest Operating Engineers Retirement Enhancement Fund; – The Midwest Operating Engineers Construction Industry Research Service Trust Fund; and – The Midwest Operating Engineers Information Technology Services Corporation. • Staff employee. A person employed by and under the direction and control of any of the following: – The Union; – An association; – The Trustees of the Midwest Operating Engineers Pension Fund; – The Trustees of the Midwest Operating Engineers Welfare Fund; – The Trustees of the Midwest Operating Engineers Retiree Welfare Fund; – The Trustees of the Operating Engineers Local 150 Apprenticeship Fund; – The Trustees of Local 150, I.U.O.E., Vacation Savings Plan, prior to December 31, 2017; – The Trustees of the Midwest Operating Engineers Construction Industry Research Service Trust Fund; or – The Midwest Operating Engineers Information Technology Services Corporation. On whose behalf such employer is obligated to make contributions to the Fund.
Eligible Provider	Eligible provider include, but are not limited to, any of the following practitioners who are licensed and/or legally authorized to practice under the laws of the state where the services are rendered. ***Facilities*** • Ambulance service • Home health care agency • Hospice • Hospital • Laboratory • Licensed ambulatory care facility • MRI centers • Residential mental health facility • Skilled nursing facility.

Term	Definition
Eligible Provider *continued*	***Physicians*** • Advanced practice nurse (A.P.N.)* • Certified mental health counselor (L.M.H.C., L.C.M.H.C., C.M.H.C.) • Certified registered nurse anesthetist (C.R.N.A) • Clinical professional counselor (L.C.P.C.) • Clinical psychologist (L.C.P.) • Clinical social worker (L.C.S.W.) • Doctor of Chiropody (D.P.M., D.S.C.) • Doctor of Chiropractic (D.C.) • Doctor of Dental Surgery (D.D.S.) • Doctor of Medical Dentistry (D.M.D.) • Doctor of Medicine (M.D.) • Doctor of Osteopathy (D.O.) • Doctor of Podiatry (D.P.M.) • Licensed acupuncturist (L.A.c., Lic. Ac.) • Licensed marriage and family therapists (LMFT) • Occupational therapist (O.T.) • Occupational therapy assistant when supervised by an O.T. • Optometrist (O.D.) • Orthoptic technician—for orthoptics only • Physical therapist (P.T.) • Physical therapy assistant—when supervised by a P.T. • Physician assistant (P.A.) • Surgical assistant (when services would be covered if performed by an M.D.) • Registered nurse (R.N.) • Speech therapist (S.L.P.). ** The maximum allowable charge will be 85% of the allowable expense for a physician performing the same service*
Experimental, Investigational, or Investigative Services	A drug, device, medical treatment or procedure is considered an experimental, investigational or investigative service: • If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; • If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval;

Term	Definition
Experimental, Investigational, or Investigative Services *continued*	• If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or • If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. "Reliable evidence" means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.
Genetic Test	"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations or chromosomal changes. Genetic tests include, but are not limited to: • A test to determine whether someone has the BRCA1 or BRCA2 variant evidencing a predisposition to breast cancer, a test to determine whether someone has a genetic variant associated with hereditary nonpolyposis colon cancer, and a test for a genetic variant for Huntington's Disease; • Carrier screening for adults using genetic analysis to determine the risk of conditions such as cystic fibrosis, sickle cell anemia, spinal muscular atrophy, or fragile X syndrome in future offspring; • Amniocentesis and other evaluations used to determine the presence of genetic abnormalities in a fetus during pregnancy; • Newborn screening analysis that uses DNA, RNA, protein or metabolite analysis to detect or indicate genotypes, mutations, or chromosomal changes, such as a test for PKU performed so that treatment can begin before a disease manifests; • Preimplantation genetic diagnosis performed on embryos created using invitro fertilization; • Pharmacogenetic tests that detect genotypes, mutations or chromosomal changes that indicate how an individual will react to a drug or a particular dosage of a drug; • DNA testing to detect genetic markers that are associated with information about ancestry; • DNA testing that reveals family relationships, such as paternity; and • Oncotype DX genomic assay genetic testing as it relates to chemotherapy treatment. The following are examples of tests or procedures that are not genetic tests: • An analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes; • A medical examination that tests for the presence of a virus that is not composed of human DNA, RNA, chromosomes, proteins or metabolites; • A test for infectious and communicable diseases that may be transmitted through food handling; • Complete blood counts, cholesterol tests and liver-function tests; and • HLA typing to determine a transplant match. With respect to alcohol and drug testing: • A test for the presence of alcohol or illegal drugs is not a genetic test. • A test to determine whether an individual has a genetic predisposition for alcoholism or drug use is a genetic test.

Term	Definition
Home Health Care	Home health care is a program of continued medical care and treatment rendered by a licensed home health care agency team at home in lieu of a hospital confinement or a stay in a skilled nursing facility. Also, it must be for the care or treatment of sick or injured persons and must be ordered in writing by the eligible person's physician; the physician must certify, in writing that without home health care, confinement in a hospital or skilled nursing facility would be required. Certification is required before benefits will be payable for home health care. Home health care consists of these services and supplies: • Part-time intermittent home nursing care from or supervised by a registered nurse; • Part-time or intermittent home health aide services; • Physical therapy, occupational therapy and speech therapy; and • Medical supplies, drugs and medications prescribed by a physician, and laboratory services, but only to the extent that they would have been covered in a hospital or skilled nursing facility. Home health care does not include: • Full-time nursing care at home; • Private duty nursing unless approved by the Case Manager in relation to a Neonatal Intensive Care Unit (NICU) case, in circumstances in which Home Health Care is more cost-effective than hospital care. Services must be in connection with a compromised airway and covered by an in-network provider; • Meals delivered to the home; or • Homemaker services
Home Health Care Agency	A home health care agency is a public agency or private organization that is licensed as a home health care agency by the state and is certified as such under Title XVIII of the Social Security Act that: • Specializes in providing nursing and other therapeutic services in the home; • Operates within the scope of its license; and • Maintains the required documentation and will furnish said documentation upon written request.
Hospice	An agency which: • Provides inpatient or outpatient hospice care, meaning a coordinated program of home and inpatient care for the special physical, psychological and social needs of terminally ill persons and their families. A terminally ill person is one who has been diagnosed by a physician as having a life expectancy of six months or less; • Is licensed as such and operating within the scope of the license; • Maintains medical records on each patient and provides an ongoing quality assurance program; • Has full-time supervision by at least one physician; and • Provides 24-hour nursing service by registered nurse.

Term	Definition
Hospital	A hospital is an institution which meets all of the following requirements: • It is mainly engaged in providing inpatient medical care for diagnosis and treatment of an injury or illness, and routinely makes a charge for such care; • It is supervised by a staff of physicians on the premises; • It provides on the premises 24 hour nursing services by registered nurses; and • It is operated with organized facilities for operative surgery on the premises, except for the following institutions: – Mental/psychiatric hospitals; – Drug/alcohol rehabilitation hospitals; and – Physical rehabilitation hospitals. A hospital does not include any institution: • Which is run mainly as a rest, nursing or convalescent home; • For which any part is mainly for the care of the aged; or • Which is engaged in the schooling of its patients.
Illness	• A person's condition when the body's organs do not function normally; or • When a temporary ailment reduces the body's ability to function normally; or • Pregnancy.
Infertility	• The inability to conceive; or • The inability to sustain a successful pregnancy.
Injury	Bodily harm resulting from an accident, which means an undesirable or unfortunate happening, unintentionally caused, resulting in harm.
Life Changing Event (Qualifying Event)	Life Changing Events include: marriage, divorce, birth of a child, death of a spouse or child, adoption of a child, gain or loss of eligibility of your dependents for group health plan coverage, insurance coverage, CHIP or Medicaid, and becoming eligible for state premium assistance, Medicaid, or CHIP subsidies.
Medically Necessary	Services and supplies that a physician, exercising prudent clinical judgment, would provide to the patient for the purpose of evaluating, diagnosing or treating an illness or injury or its symptoms, and: • Have been established as safe and effective by the American Medical Association or appropriate governing body; • Are furnished in accordance with generally accepted professional medical standards for treatment of illness or injury; • Are consistent with the signs, symptoms or diagnosis and treatment of an illness or injury; • Are not primarily for the convenience of the eligible person or his or her doctor; • Are the most appropriate supply or level of service which can be safely provided; • Are necessary and appropriate treatment of the illness or injury; • Are not experimental or investigative in nature; and • Are not cosmetic in nature; that is, the treatment restores or repairs function. The fact that a physician or other health care provider deems a service to be medically necessary is not binding on the Trustees.
MinuteClinic	Health care facilities located in CVS and Target stores designed to offer an alternative to a physician's office visit for treatment of unscheduled and/or non-emergency illnesses or injuries. These facilities also offer, among other things, wellness screenings, preventive care and administration of certain vaccines or immunizations. MinuteClinics do not provide an alternative for emergency services or the ongoing care provided by a physician. MinuteClinics must be licensed and certified as required by any applicable state or federal law or regulation and must be staffed by the required licensed practitioners. Benefits are subject to any applicable maximum or limitation specified on the Schedule of Benefits.



Term	Definition
MOE's Health Plan Marketplace	The Health Plan Options offered under the MOE Active Plan are collectively referred to herein as MOE's Health Plan Marketplace.
Monthly Staff Employee	Employees of the International Union of Operating Engineers Local 150, the Fund Office, the Operating Engineers Local 150 Apprenticeship site, MOEITS, the Midwest Operating Engineers Credit Union, the Foundation for Fair Contracting, and the Illinois Economic Policy Institute.
Owner Operator/Relative Shareholder	A corporate shareholder, officer and/or director, or a relative (as defined in the collective bargaining agreement) of a shareholder, officer and/or director.
Private Duty Nursing	Private Duty Nursing, when approved by the Case Manager and meets the following conditions: • Is related to a Neonatal Intensive Care Unit (NICU) case, including circumstances in which Home Health Care is more cost-effective than hospital care; • Involves a compromised airway; and • Is covered by an in-network provider.
Public Health Exchange Marketplace	The Federal or State Health Insurance Marketplace.
Reasonable and Customary Charge	• With respect to a PPO provider, the reasonable and customary charge means the charges set forth in the agreement between the PPO provider and the PPO or the Plan. • With respect to non-PPO providers, the charge for medically necessary services or supplies will be determined by the Administrative Manager or its designee to be the lowest of: – The usual charge by the provider for the same or similar service or supply; – No more than the prevailing charge of the providers in the same or similar geographic area for the same or similar health care service or supply; or – The provider's actual charge. • With respect to providers who are unsolicited or in cases of emergency, the charge for medically necessary services or supplies will be determined by the Administrative Manager or its designee. The "prevailing charge" of most other providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the Administrative Manager who will use proprietary data that is updated no less frequently than annually, and provided by a reputable company or entity. For Medicare-eligible participants, the amount approved by Medicare
Residential Mental Health Facility	A facility designed for patients who need around-the-clock behavioral care but do not need the high level of physical security and frequency of psychiatric and nursing intervention that are available on an inpatient unit. Patients admitted to residential care are usually voluntary and unlikely to need physical restraint or extensive nursing care.

Term	Definition
Totally Disabled, Total Disability, Disability	A person is considered to be disabled or totally disabled if it has been established to the satisfaction of the Trustees based upon competent medical evidence provided by a physician that: • With respect to a member, the member is unable to perform any of the duties of his or her occupation or any occupation as a result of a non-work-related illness or injury, or, subject to the subrogation provisions of the Plan set forth in Article 16, a work-related illness or injury. • With respect to a dependent, the dependent is unable to perform the normal activities or duties of a person of the same age and sex as a result of a non-work-related illness or injury.
Work-Related Illness or Injury	Illness or injury, which arises from or is sustained in the course of work for pay, profit or gain.

ADMINISTRATIVE INFORMATION

This section provides you with information about how the Midwest Operating Engineers Retiree Welfare Plan is administered.

Name of Plan	Welfare Plan of the Midwest Operating Engineers Retiree Welfare Fund
Plan Sponsor and Administrative Manager	Board of Trustees Midwest Operating Engineers Retiree Welfare Fund 6150 Joliet Road Countryside, Illinois 60525 708-482-7300 The Board of Trustees consists of an equal number of employer and union representatives, selected by the employers and Local 150 I.U.O.E., which have entered into collective bargaining agreements, which relate to this Plan. The Board of Trustees is responsible for the operation of the Plan.
Administrative Manager	**Mr. Thomas M. Bernstein**. The Administrative Manager is an employee of the Fund who assists the Trustees in the administration of the Plan.
Employer Identification Number (EIN)	37-1752023
Plan Number	502
Funding of the Plan	This is a self-insured welfare plan governed by federal laws and not state laws. This Plan is funded primarily through employer contributions. Self-pay contributions are also used for funding. The amount of employer contributions and the individuals on whose behalf contributions are required to be made are determined by the provisions of the collective bargaining agreements between employers and employer associations, and Local 150. The collective bargaining agreements require contributions to the Fund and stipulate the method for determining the amount to be contributed and the date such contributions are due. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to the Plan on behalf of covered members pursuant to a collective bargaining agreement. The Fund Office will also provide you, at cost and upon written request, copies of the collective bargaining agreements. Administrative employees of the Fund are also entitled to participate in the Plan. The Fund may also receive rebates from its pharmacy benefits manager. The Fund provides medical, surgical, hospital, prescription drug and dental/orthodontia benefits on a self-insured basis. When benefits are self-insured, the benefits are paid directly from the Fund to the claimant or beneficiary. The self-insured benefits payable by the Fund are limited to the Fund assets available for such purposes. As described earlier in this Summary Plan Description, BlueCross re-prices PPO claims involving medical, surgical and hospital benefits, and Delta Dental re-prices dental PPO claims. However, these services are limited to the amount the Fund must pay providers, and all benefits paid remain self-insured. This Plan is not an insurance policy and no benefits are provided through an insurance company. The complete list of employers is available upon written request. A copy of the collective bargaining agreement(s) are available for examination.
Welfare Fund Assets and Reserves	The title to all assets is held by the Trustees in their representative capacity for the purpose of providing benefits to eligible retirees and their eligible dependents and defraying reasonable administrative expenses.
In-Network Providers	Because providers are added to and dropped from the network periodically throughout the year it is best if you ask your health care provider IF they are still participating with the network, or contact the network each time BEFORE you seek services. For a list of network providers, visit www.bcbsil.com. For a paper copy of the provider directory, contact BCBSIL.
Name of Plan	Welfare Plan of the Midwest Operating Engineers Retiree Welfare Fund

Calendar Year	The calendar year begins January 1 and ends the following December 31. The Plan Year follows begins and ends on the same day as the calendar year. Records are maintained on a Plan Year basis.
Agent for Service of Legal Process	**Travis J. Ketterman, Esq.** McGann, Ketterman & Rioux 111 East Wacker Drive Suite 2600 Chicago, Illinois 60601-4208 or **Michael W. Duffee, Esq.** Thompson Coburn LLP 55 East Monroe Street Suite 2900 Chicago, Illinois 60603-5209 Legal process also may be served on the Plan Trustees.

If you have any questions about your benefits or if you need to provide updated address, dependent or beneficiary information, please contact the Fund Office. Also, you have the right to get answers from the Trustees. You are also guaranteed specific rights under ERISA, as outlined on page 57.

GETTING ACCURATE INFORMATION

As you know, benefits are paid in accordance with Plan provisions out of a trust fund used for that purpose. Remember that although this book provides accurate and essential information about the Retiree Welfare Plan, it is not a complete description. If there is ever a conflict between this book and the Plan's legal document, the Plan Document will control.

BOARD OF TRUSTEES

Union Trustees	Employer Trustees
Mr. James M. Sweeney Fund Chairman President and Business Manager Local 150 I.U.O.E. 6200 Joliet Road Countryside, Illinois 60525	**Mr. David Snelten** Fund Secretary-Treasurer Excavators, Inc. 759 Ridgeview Drive McHenry, Illinois 60050
Mr. Steven M. Cisco Recording-Corresponding Secretary Local 150 I.U.O.E. 6200 Joliet Road Countryside, Illinois 60525	**Mr. Mark Barkowski** Illinois Road & Transportation Builders Assoc. EAS OH #1014 KIC 8501 W. Higgins Road, Suite 400 Chicago, Illinois 60631
Mr. Marshall Douglas Treasurer Local 150 I.U.O.E. 3511 78th Avenue West Rock Island, Illinois 61201	**Mr. Frank A. Lizzadro** Meade 625 Willowbrook Center Parkway Willowbrook, Illinois 60527
Mr. Dave A. Fagan Financial Secretary Local 150 I.U.O.E. 2193 West 84th Place Merrillville, Indiana 46410	**Mr. Steve Michaels** Northwest Indiana Contractors Association Superior Construction 2045 E. Dunes Highway Gary, Indiana 46402-1601
Mr. Mike Kresge Vice President Local 150 I.U.O.E. 6200 Joliet Road Countryside, Illinois 60525	**Mr. Mike Piraino** Underground Contractors Association PirTano Construction Company 1766 Armitage Court Addison, Illinois 60101
	Mr. Daniel Plote Northern Illinois Material Producers Association Beverly Materials 1100 Brandt Drive Hoffman Estates, Illinois 60192

NONDISCRIMINATION NOTICE UNDER SECTION 1557 OF THE AFFORDABLE CARE ACT

DISCRIMINATION IS AGAINST THE LAW

Midwest Operating Engineers Health and Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Midwest Operating Engineers Health and Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Midwest Operating Engineers Health and Welfare Fund:

- 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 that Midwest Operating Engineers Health and Welfare Fund 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 Health and Welfare Fund, 6150 Joliet Road, Countryside, Illinois 60525-3994, Telephone: 708-482-7300, Fax: 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, District of Columbia 20201
800-368-1019, 800-537-7697 (TDD)

Complete 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 708-482-7300.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 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 708-482-7300.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 708-482-7300. 번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 708-482-7300.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 708-482-7300.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 708-482-7300.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 708-482-7300.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 708-482-7300.
Hindi	ध्यान द: यद आप हदी बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 708-482-7300. पर कॉल कर।
Gujarati	ચુના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 708-482-7300.
Urdu	نیرک رادربخ: رگا پآ ودرا ےتلوب نیہ، وت پآ وک نابز یک ددم یک تامدخ تفم نیم بایتسد نیہ ۔ لاک 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 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 708-482-7300.
Arabic	قظوحلم: اذإ تنك ثدحتت ركذا ةغللا، نإف تامدخ ةدعاسملا قيوغلا رفاوتت كل ناجلاب. لصتا مقرب (مقر 708-482-7300. .
Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 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。 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 708-482-7300.
Lao	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 708-482-7300.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 708-482-7300.
Karen	ဟသူဉ်ဟသး–နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ် ကျိာ်အတ်မၤစၢၤလၢ တလၫ်ဘူဉ်လၫ်စုၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိ; 708-482-7300.
Dutch	AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 708-482-7300.
Panjabi	ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 708-482-7300. 'ਤੇ ਕਾਲ ਕਰੋ।


BUY
WAR BONDS
AND
STAMPS