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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300/individual or $700/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, DME, TMJ, dental, covered services received through a direct contract preferred vendor or through a preferred Local 150 primary medical home, and in-network prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,500/individual or $6,000/family	The out-of-pocket limit is the most you could pay in a year for covered services (unless you exceed the plan's overall annual limit described below). If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, Family Supplemental Benefits, durable medical equipment,dental benefits administered separately through a direct contract preferred dental vendor, prescription drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	Yes. **$2,000,000**/individual overall limit.	This retiree-only plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.

Will you pay less if you use a network provider?	Yes. Call 1-800-810-2583 for a list of medical network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	None
	Specialist visit	10% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Member, spouse only: $750 calendar year maximum applies separately to member and spouse. No charge for well-baby care through age 24 months. There is also no charge for preventive services received through a preferred Local 150 primary medical home or a through a direct contract preferred urgent care vendor. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Eligible individuals are encouraged to use the direct contract preferred imaging network.
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at https://www.OptumRX.com/sign-ins.html or 1-855-697-9150.	Generic drugs (Tier 1)	$5 copay/fill per 30-day supply/retail; $15 copay/fill per 90-day supply. Deductible does not apply.	Not covered	Maximum of up to two 30-day supplies, before a member is required to obtain a 90-day supply. Member seeking third refill must transition to the preferred retail pharmacy or the Pharmacy Benefit Manager's home delivery pharmacy or the member will be required to pay 100% of the cost of the prescription drug. If you choose to take a brand name drug when there is a generic drug available, you must pay the difference between the cost of a brand and generic plus the brand name copay. Certain specialty medications are subject to preauthorization requirements. Failure to obtain approval will result in the non-payment of benefits.
	Preferred brand drugs (Tier 2)	$10 copay/fill per 30-day supply/retail; $30 copay/fill per 90-day supply. Deductible does not apply.	Not covered	
	Non-preferred brand drugs (Tier 3)	$25 copay/fill per 30-day supply/retail; $45 copay/fill per 90-day supply. Deductible does not apply.	Not covered	
	Specialty drugs (Tier 4)	$100 copay/fill per 30-day supply. Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Licensed facilities only. Case Manager must approve. Failure to obtain approval may result in the non-payment of benefits.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance	20% coinsurance	Professional/physician charges may be billed separately, and different coinsurance may apply.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Transfer between inter-health facilities is limited to $5,000.
	Urgent care	10% coinsurance	20% coinsurance	No charge if received through a direct contract preferred urgent care vendor.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Room allowances based on semi-private room. Case manager must approve. Failure to obtain approval may result in the non-payment of benefits.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	None
	Inpatient services	10% coinsurance	20% coinsurance	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits.
	Rehabilitation services	10% coinsurance	20% coinsurance	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. No charge and not subject to the deductible if received at a preferred Local 150 primary medical home or a direct contract preferred physical therapy facility.
	Habilitation services	10% coinsurance	20% coinsurance	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. Limited to $2,000 for individuals (age 2-5) or $500 for individuals (6-18) with congenital neurological disorder.
	Skilled nursing care	10% coinsurance	20% coinsurance	45-day limit per confinement; Physician must recommend, and care must begin within 30 days of hospital confinement. Case manager must approve. Failure to obtain approval may result in the non-payment of benefits.
	Durable medical equipment	20% coinsurance. Deductible and the out-of-pocket limit does not apply.	20% coinsurance. Deductible and the out-of-pocket limit does not apply.	Case manager approval is required for amounts over $1,000. Failure to obtain approval may result in the non-payment of services; $15,000 limit/electric wheelchair.
	Hospice services	10% coinsurance	20% coinsurance	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Eye exams and glasses are reimbursable under the Family Supplemental Benefit. You can receive basic vision care at no charge from a preferred Local 150 primary medical home.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Coverage limited to two exams per Plan Year. Administered separately through a direct contract preferred dental vendor.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery (except for mastectomy, injuries, and to remove scar tissue)
- Hearing aids (except for cochlear implants)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture ($125 per visit, 12 per year)
- Bariatric surgery (2 per lifetime maximum; Prior authorization required)
- Chiropractic care (Limited to $60/visit and 24 visits/year)
- Dental care (Adult-$1,500 annual limit; Child-No maximum; administered separately through a direct contract preferred dental vendor)
- Private-duty nursing (for transplant patients and certain NICU Cases)
- Routine eye care (Eligible for reimbursement from Family Supplemental Benefit)
- Non-routine treatment for flat feet will be covered if approved by the Case Manager and services are medically necessary

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

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

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

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

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

Does this plan meet the Minimum Value Standards? **Yes**

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

Language Access Services:

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$300
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Prescription Drug Copayments	$10
Coinsurance	$1,190
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

The plan's overall deductible	$300
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Prescription Drug Copayments	$350
Coinsurance	$ 60
What isn't covered	
Limits or exclusions	$680
The total Joe would pay is	**$1,390**

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

The plan's overall deductible	$300
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Prescription Drug Copayments	$10
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$560**

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