



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, visit local150.org/moe/ or call 1-708-579-6600. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at local150.org/moe/ or call 1-708-579-6600 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical In-network : \$1,000/individual or \$2,500/family; Medical Out-of-network : \$2,000/individual or \$5,000/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 , Durable Medical Equipment (DME) , TMJ, dental, orthoptic training, covered services received through a direct contract preferred vendor or at a Local 150 Health Center, 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?	Medical In-network : \$4,000/individual or \$8,000/family; Medical Out-of-network : \$8,000/individual or \$16,000/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, DME, 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 .

Important Questions	Answers	Why This Matters:
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 below describes <i>specific</i> 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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No charge. Deductible does not apply.	Not covered	No charge for well-baby care through age 24 months. There is also no charge for preventive services received at a Local 150 Health Center (Operators' Health Centers (OHC), Marathon Health Centers, and Midwest Coalition of Labor Health Centers (MCL Health Centers)) or through a direct contract preferred vendor for member, spouse, or covered dependents over 24 months. Routine colonoscopies are not covered at 100% and are subject to the comprehensive medical benefit. 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. Immunizations received at the pharmacy will require a copay, which is not reimbursable under the FSB.

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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Eligible individuals are encouraged to use the direct contract preferred imaging network. No charge and deductible does not apply if services are rendered through the direct contract preferred imaging network. PET scans are not subject to the deductible.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or 1-833-252-6642.	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 drugs are subject to preauthorization requirements. Failure to obtain approval will result in the non-payment of benefits. ¹ The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty drug , the member will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution. ² Some specialty drugs are required to be filled for more than a 30-day supply due to packaging which will result in higher copay amount based on the day supply filled.
	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) ¹	\$100 copay /fill per 30-day supply, \$300 ² copay /fill per 90-day supply. Deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Licensed facilities only. Case Manager must approve. Failure to obtain approval may result in the non-payment of benefits.
	Physician/surgeon fees	20% coinsurance	40% 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	\$100 copay /visit; 20% coinsurance	\$100 copay /visit; 20% coinsurance	Professional/physician charges may be billed separately, and different coinsurance may apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Transfer between inter-health facilities is limited to \$5,000.
	Urgent care	20% coinsurance	40% 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)	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	IOP and PHP require approval by the Case manager. Failure to obtain approval may result in the non-payment of benefits. No charge and not subject to the deductible if received at a Local 150 Health Center or a direct contract preferred substance abuse facility.
	Inpatient services	20% coinsurance	40% 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 Health Center or a direct contract preferred substance abuse facility.
If you are pregnant	Office visits	Prenatal care: No charge. Deductible does not apply. All other visits: 20% coinsurance	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits.
	Rehabilitation services	20% coinsurance	40% coinsurance	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. Non-surgical: No authorization is needed for up to 24 visits. Surgical: No authorization is needed for up to 36 visits. No charge and not subject to the deductible if received at a Local 150 Health Center or a direct contract preferred physical therapy facility.
	Habilitation services	20% coinsurance	40% coinsurance	Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. Must be performed by a licensed provider.
	Skilled nursing care	20% coinsurance	40% 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	40% coinsurance . Deductible does not apply. Out-of-pocket limit does not apply.	40% coinsurance . Deductible does not apply. Out-of-pocket limit does not apply.	Case manager approval is required for amounts over \$1,500. Failure to obtain approval may result in the non-payment of services; Power wheelchair limited to \$15,000.
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Eye exams and glasses are reimbursable under the Family Supplemental Benefit.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Coverage limited to two exams per plan Year. Administered separately through a direct contract preferred dental vendor.

Excluded Services & Other Covered Services:

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

- 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
- Commercial weight loss programs (e.g., Jenny Craig, Weight Watchers)

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)
- Private duty nursing (for transplant patients and certain NICU Cases)
- Routine eye care (Eligible for reimbursement from Family Supplemental Benefit)
- Dental care (Adult-\$2,000 annual limit; Child-No maximum; administered separately through a direct contract preferred dental vendor)

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

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 1-708-482-7300.

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

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	\$1,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Prescription Drug Copayments	\$10
Coinsurance	\$2,030
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,100

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$910
Prescription Drug Copayments	\$350
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$180
The total Joe would pay is	\$1,440

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Prescription Drug Copayments	\$110
Coinsurance	\$340
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,450

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.