

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

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall <u>deductible</u>? | \$300/individual or \$700/family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. <u>Preventive care</u> , <u>DME</u> , <u>TMJ</u> , dental, physical therapy treatment received at an ATI facility, and <u>in-network prescription drugs</u> are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | \$2,500/individual or \$6,000/family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services (unless you exceed the <u>plan's</u> overall annual limit described below). If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges, Family Supplemental Benefits, dental benefits administered separately by Delta Dental, <u>prescription drugs</u> , and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Is there an overall annual limit on what the <u>plan</u> pays? | Yes. \$2,000,000 /individual overall limit and \$30,000 /individual maximum annual benefit for <u>prescription drugs</u> . | This retiree-only <u>plan</u> 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 <i>specific</i> coverage limits, such as limits on the number of office visits. |
| Will you pay less if you use a <u>network provider</u>? | Yes. Call 1-800-810-2583 for a list of medical <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| | | |
|---|----------------------------|---|
| Do you need a referral to see a <u>specialist</u> ? | Yes. For acupuncture only. | This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |
|---|----------------------------|---|

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No charge. <u>Deductible</u> does not apply. | No charge. <u>Deductible</u> does not apply. | Member, spouse only: \$750 calendar year maximum applies separately to member and spouse. No charge for well-baby care up to 24 months. There is also no charge for <u>preventive services</u> available at Operators' Health Center. No charge if a MinuteClinic (CVS/Target retail stores) is used. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% <u>coinsurance</u> | 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 drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at https://www.OptumRX.com/sign-ins.html or 1-855-697-9150. | Generic drugs (Tier 1) | \$5 <u>copay</u> /fill per 30-day supply/retail; \$15 <u>copay</u> /fill per 90-day supply. <u>Deductible</u> does not apply. | Not covered | Maximum of up to two 30-day supplies, before a member is required to obtain a 90-day supply. Member seeking third refill must transition to a CVS retail pharmacy or the OptumRx home delivery pharmacy or the member will be required to pay 100% of the cost of the <u>prescription drug</u> . If you choose to take a brand name drug when there is a generic drug available, you must pay the difference between the cost of a brand and generic plus the brand name <u>copay</u> . Certain specialty medications are subject to <u>preauthorization</u> requirements. Failure to obtain approval will result in the non-payment of benefits. Your <u>cost sharing</u> for <u>in-network prescription drugs</u> counts toward your <u>prescription drug out-of-pocket limit</u> . |
| | Preferred brand drugs (Tier 2) | \$10 <u>copay</u> /fill per 30-day supply/retail; \$30 <u>copay</u> /fill per 90-day supply. <u>Deductible</u> does not apply. | Not covered | |
| | Non-preferred brand drugs (Tier 3) | \$25 <u>copay</u> /fill per 30-day supply/retail; \$45 <u>copay</u> /fill per 90-day supply. <u>Deductible</u> does not apply. | Not covered | |
| | <u>Specialty drugs</u> (Tier 4) | \$100 <u>copay</u> /fill per 30-day supply. <u>Deductible</u> does not apply. | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | Licensed facilities only. Case Manager must approve. Failure to obtain approval may result in the non-payment of benefits. |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | Professional/physician charges may be billed separately, and different <u>coinsurance</u> may apply. |
| | <u>Emergency medical transportation</u> | 10% <u>coinsurance</u> | 10% <u>coinsurance</u> | Transfer between inter-health facilities is limited to \$5,000. |
| | <u>Urgent care</u> | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | No charge if a MinuteClinic (CVS/Target retail stores) is used. |

| 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 hospital stay | Facility fee (e.g., hospital room) | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | Room allowances based on semi-private room. |
| | Physician/surgeon fees | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | Inpatient services | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. |
| If you are pregnant | Office visits | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | None |
| | Childbirth/delivery professional services | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. |
| | <u>Rehabilitation services</u> | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. No charge and not subject to the <u>deductible</u> if received at an ATI Physical Therapy facility. |
| | <u>Habilitation services</u> | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. Limited to 25 visits for <u>plan</u> year for speech therapy for individuals (age 2 to 18) with congenital neurological disorder. |

| 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) | |
| | <u>Skilled nursing care</u> | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | 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. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> . <u>Deductible</u> does not apply. | 20% <u>coinsurance</u> . <u>Deductible</u> 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. |
| | <u>Hospice services</u> | 10% <u>coinsurance</u> | 20% <u>coinsurance</u> | Case manager must approve. Failure to obtain approval may result in the non-payment of benefits. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Eye exams and glasses are reimbursable under the Family Supplemental Benefit. You can receive basic vision care at no charge from the Operators' Health Center. |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | No charge. <u>Deductible</u> does not apply. | No charge. <u>Deductible</u> does not apply. | Coverage limited to two exams per <u>Plan</u> Year. Administered separately by Delta Dental. |

Excluded Services & Other Covered Services:

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

- Cosmetic surgery (except for mastectomy, injuries, and to remove scar tissue)
- Hearing aids (except for cochlear implants)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except for transplant patients)
- 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; manipulations and necessary x-rays only)
- Dental care (Adult-\$1,500 annual limit; Child-No maximum; administered separately by Delta Dental)
- Routine eye care (Eligible for reimbursement from Family Supplemental Benefit)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Administrative Manager, Midwest Operating Engineers Fringe Benefit Funds, 6150 Joliet Road, Countryside, IL 60525-3994, 1-708-482-7300. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

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

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The 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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$300 |
| Prescription Drug Copayments | \$20 |
| Coinsurance | \$1,230 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,610 |

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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$300 |
| Prescription Drug Copayments | \$420 |
| Coinsurance | \$ 50 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$1,430 |
| The total Joe would pay is | \$2,200 |

(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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$300 |
| Prescription Drug Copayments | \$0 |
| Coinsurance | \$160 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$460 |