

**HEALTH AND WELFARE PLAN OF THE
MIDWEST OPERATING ENGINEER HEALTH AND
WELFARE FUND**

Summary Plan Description

HEALTH AND WELFARE FUND
MIDWEST OPERATING ENGINEERS

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Midwest Operating Engineers Health and Welfare Plan
IMPORTANT PHONE NUMBERS

Call	For	Phone Number
Office Pharmacy	Prescriptions	(708) 579-6610
	24/7 Toll Free Automated Refill line	(866) 850-9310
	Physician Fax Line	(708) 354-2642
Fund Office	General information	(708) 482-7300
		(800) 323-3060
	Claims Department	(708) 579-6600
	Medical claims	
	Dental claims	
	Disability claims	
	General Welfare Fund benefits	
	Active Eligibility	
	Active participant self-payments	(708) 579-6620
	Hour transfers to other funds	
	COBRA	(708) 579-6635
Eligibility		
Applications		
Payment information		
Pension	(708) 579-6640	
Applications		
Retiree Eligibility		
Members Assistance Program (MAP)	Mental Health	Administered by ComPsych
	Chemical/Substance Abuse Treatment	(888) 327-4315
	Personal Issues	
Illinois Blue Cross Blue Shield	To find a PPO hospital or doctor	(800) 810-2583 or
		log on to www.bcbsil.com
Guardian (Dental)	For a list of network dental providers	(888) 600-2580
Medlink Health Care (MRI/Cat Scan)	To find a provider	(888) 558-0680

MIDWEST OPERATING ENGINEERS HEALTH AND WELFARE FUND

To All Participants:

Affordable health care coverage today is a major concern for all of us. As an active or retired participant in the Midwest Operating Engineers Health and Welfare Plan, you and your family receive substantial medical benefits. Other benefits, such as death benefits and weekly disability benefits, are also available to active members.

You are able to enjoy such a high level of benefits because of the cooperative efforts of the Trustees of the Midwest Operating Engineers Health and Welfare Fund. The Trustees include members of both union and employer groups who participate in the Midwest Operating Engineers Health and 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 booklet is a summary plan description (SPD) of your Health and Welfare Plan as of July 1, 2001. It explains:

- who is eligible for coverage;
- when coverage begins and ends; and
- the Comprehensive Medical, Prescription Drug, Dental, Family Supplemental, Weekly Disability, Death, and Accidental Dismemberment Benefits.

As you receive benefit announcements and updates, put them in the back pocket of this SPD. *Please keep all of your benefit materials together in a safe place for future reference.*

Although this booklet 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 booklet and the plan's legal documents, the plan's legal documents will control. If you have questions about the Midwest Operating Engineers Health and Welfare Plan, please contact the Fund Office. Fund Office staff will be happy to help you.

Sincerely,

Board of Trustees

The benefits described in this booklet generally apply to expenses incurred by eligible persons on or after July 1, 2001.

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 method and amount of self-payments and the eligibility criteria for self-payments under the plan. You will be notified of any changes and all changes would be subject to the plan's provisions and applicable laws.

You can click on the links below to jump to the appropriate page in the document.
Remember to return to the Table of Contents, to easily navigate through the document.

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BENEFIT HIGHLIGHTS

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.

The following highlights the major features of the plan. For more detail, see the complete description in the pages that follow.

1. **Comprehensive Medical Coverage**

Covers most medical expenses up to \$50,000 per calendar year with supplemental lifetime coverage of up to \$750,000. 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 (limited to a \$700 per family deductible maximum).

Most plan benefits are payable as follows:

In-Network (PPO Provider):	90%
Out-of-Network (Non-PPO Provider):	80%

Other certain special coverages are payable at 50%. See page 35 for a description of covered expenses.

You receive higher benefit coverage when you go to a medical provider associated with one of the plan's PPO networks. The plan's PPO networks consist of doctors and hospitals that offer discounts on quality services for our members. For more information about the PPO providers go to page 32.

Prescription Drug

Prescription drug benefits are described on pages 46 to 54.

Dental Benefits

Dental benefits are described beginning on page 55.

Weekly Disability Benefits

Active employees who are unable to work due to a disability are eligible for weekly benefits. See page 19.

Death Benefit and Accidental Dismemberment Benefit

To help defray costs in the event of death, death benefits are provided for active employees and their eligible dependents (page 65). Also, active employees can receive benefits for certain covered losses that result from accidental injury as described on page 66.

Family Supplemental Benefit

Active employees can receive up to \$1,500 per family for medically necessary out-of-pocket healthcare expenses a year as described on page 61.

PARTICIPATION

You are eligible to participate in this plan if you work under the jurisdiction of Operating Engineers Local 150 and/or your employer is required to make contributions on your behalf to the Midwest Operating Engineers Welfare Trust Fund. Once you can participate, you are eligible for plan benefits when you satisfy the coverage requirements.

Special Participation Provisions

Plan participants include certain groups of individuals who are covered by the plan when they satisfy different eligibility for coverage requirements. For more information about special coverage requirements, contact the Fund Office for the appropriate materials.

If you fall into one of the groups listed below, you should read the eligibility insert you received in the back pocket of this SPD:

- Your Employer is The Forest Preserve; or
- Your Employer is The City of Chicago; or
- Your Employer is the Union; or
- Your Employer is the Fund Office; or
- Your Employer is a Municipality; or
- You are a Landscaper; or
- You are a non-bargained employee.

ELIGIBILITY FOR COVERAGE

Your Eligibility

Your eligibility for coverage under this plan depends on the number of hours you work under the jurisdiction of the I.U.O.E. Local 150 Collective Bargaining Agreements or other applicable Collective Bargaining Agreements for an employer who is required to contribute to the Midwest Operating Engineer Health and Welfare Fund. If you work for more than one employer who is required to contribute to the Fund, you will be credited with the total amount of contributions made by all your employers. You are first eligible for coverage after you are credited with 300 hours during a contribution quarter.

If you fall into one of the groups listed below, you should read the eligibility insert you received in the back pocket of this SPD:

- Your Employer is The Forest Preserve; or
- Your Employer is The City of Chicago; or
- Your Employer is the Union; or
- Your Employer is the Fund Office; or
- Your Employer is a Municipality; or
- You are a Landscaper; or
- You are a non-bargained employee.

You must establish eligibility for coverage at the end of each contribution quarter in order to be covered during the related benefit quarter. These periods are specified below.

Benefit Quarter

You will be covered during this 3-month period:

January, February, March

April, May, June

July, August, September

October, November, December

Contribution Quarter

If you meet the eligibility requirements during this 3-month period:

August, September, October

November, December, January

February, March, April

May, June, July

Your eligibility is determined based on the number of hours, during a contribution quarter, that employer contributions were required to be made on your behalf.

To continue to satisfy the eligibility requirements, you must be credited with:

- at least 300 hours during a contribution quarter; or
- at least 1,200 hours during the last *four* contribution quarters.

You receive Quarterly Status Reports that detail your contribution hours for the prior contribution quarter. You should compare your hours worked with your check stubs. If there is a discrepancy, call the Fund Office immediately

The following examples show how eligibility is determined using these two rules:

Example - 1

Joe is credited with 90 hours in May 2001, 120 hours in June 2001, and 110 hours in July 2001, for a total of 320 hours in this contribution quarter. He will be eligible and covered for plan benefits in the related benefit quarter - October, November and December 2001 because he was credited with at least 300 hours during the corresponding contribution quarter.

Example - 2

Let's say Joe did *not* have at least 300 hours in the May, June, July 2001 contribution quarter. He still may be eligible under Rule 2. For example, if Joe is credited with the following hours:

Contribution Quarter	Hours
May, June, July 2001	200
February, March, April 2001	300
November, December 2000; January 2001	350
August, September, October 2000	<u>400</u>
	1,250

Joe would be eligible and covered for plan benefits in the related benefit quarter -October, November and December 2001 - because he was credited with at least 1,200 hours during the last four contribution quarters.

Eligibility may be different if you qualify for coverage under Special Participation Provisions (see page 3).

Dependents' Eligibility

During any benefit quarter that you are eligible for coverage, your eligible dependents are also covered. Eligible dependents include your:

- legal spouse other than a spouse separated by a decree of a court of competent jurisdiction; and
- unmarried children (including legally adopted children* or step-children**) provided they are:
 - under age 19;
 - a full-time student between the ages of 19 and 23; or
 - physically or mentally incapacitated and unable to support themselves.

* *A child is considered legally adopted on the earlier of the date of placement or the date legal adoption proceedings have been started.*

** *A stepchild must be a natural or adopted child of an eligible spouse.*

Full-Time Student Status

To qualify for continued coverage as a full time student after the age 18, the individual must be an eligible dependent under the plan at the time they turn 19 years of age. The Fund Office requires proof every semester of full-time student status for children age 19 and older. Documentation must come from the registrar's office, and must include a school seal or class schedule.

Full-time student is a dependent child, age 19-23, that attends an accredited college, university or trade school on a full-time basis as defined by the school, generally, 12 credits.

The full-time student is covered until the end of the calendar quarter that includes the last day of the semester or quarter for which the student provided documentation of full-time student status. At the end of the normal school year, full-time students are covered through June 30th. If the child continues as a full-time student the following fall, then the child is covered during the summer months. Otherwise, coverage ends June 30th.

If your child is not continuously a full-time student but maintains coverage under the plan by electing continuation of coverage under COBRA, then when he or she first becomes or returns to full-time student status, he or she will be considered an eligible dependent. This change from non-dependent to dependent status is permitted only once.

Proof of Child's Disability

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 19th birthday.

Extension of Eligibility

If you are a non-retired, active employee, there are certain situations under which you may be eligible to continue coverage for yourself and your dependents if you do not meet the quarterly eligibility requirements.

You can continue coverage:

- For up to four consecutive benefit quarters, if you become unemployed and are actively seeking employment with employers who are required to contribute to the Fund.
- During periods you receive a Weekly Disability Benefit (as described on page 19). In this case, you are credited with 40 hours per week, up to a maximum of 17 weeks for eligibility purposes under this plan.
- For up to four consecutive benefit quarters if you are disabled and are unable to work.

Coverage will only be continued as long as you make continuous payments to the Fund at the time and in the amount determined by the Trustees. When the maximum self-payment period under this provision ends, you may be eligible for COBRA continuation coverage. See *Your Continuation Coverage Under COBRA* on page 10.

This provision does not apply to certain eligibility groups such as owner operators/shareholders/relatives or non-bargaining.

Reciprocal Agreements

You may also be eligible for coverage under this Plan if you are covered by another collective bargaining unit's plan, and that plan has a reciprocal agreement with the Midwest Operating Engineer Health and Welfare Fund. To continue coverage, you must arrange to transfer your credited hours to the Midwest Operating Engineer Health and Welfare Fund.

The number of hours transferred into the Fund is determined by using the following formula:

the monthly dollar amount that is
transferred to the Midwest Operating Engineers
Health and Welfare Fund

divided by

the contribution rate for that month in the
Collective Bargaining Agreement that covers
Heavy and Highway Work in Illinois

To transfer hours you must complete a Transfer Agreement with this Fund no later than six months from the time the hours to be transferred are worked.

WHEN COVERAGE STOPS

You lose coverage if:

- You do not meet the eligibility requirements described on page 4,
- Your Employer no longer contributes to the Fund, or
- You die.

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

- Your divorce,
- A child no longer meets the definition of a dependent child, or
- A dependent dies.

If you or your dependents lose coverage, you may be eligible for COBRA continuation coverage. See the next section for details.

Your coverage may also end if your employer is no longer required to contribute to the Fund under a collective bargaining agreement or other applicable written agreement. In that case, your coverage ends on the 30th day after the last day the employer's obligation to contribute terminated.

If your coverage ends because you do not meet the eligibility requirements, you do not make a self-payment on time or your employer is no longer required to contribute to the Fund, coverage for your eligible dependents will end. A dependent's coverage will also end if he or she no longer meets the plan's definition of "dependent". Remember, though, you and/or your dependents may be eligible to continue coverage through self-payments.

Your 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*. In certain situations it extends your plan coverage when you are no longer eligible for plan benefits under either the regular eligibility rules or the special eligibility rules described on page 7.

As an eligible employee covered by this plan, you, your spouse and your dependent children have the right to continuation coverage if you lose coverage due to one of the following events:

- your employment ends for reasons other than gross misconduct;
- your hours of employment are reduced; or
- your employer is no longer required to contribute to the Midwest Operating Engineers Welfare Fund on your behalf.

Additionally, your spouse and dependent children have the right to continuation coverage under COBRA if:

- you become divorced or legally separated;
- you become eligible for Medicare benefits;
- you die; or
- a dependent child no longer meets the definition of a dependent child.

If your employment ends, your hours of employment are reduced or your employer no longer contributes to the Fund, you will be notified of your right to continuation coverage by the Fund Office.

Under COBRA, 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.

You will then be notified of your right to continuation coverage and the deadline for electing continuation coverage.

If you choose continuation coverage, you will be provided with the medical coverage available to active employees. You will have to pay for the full amount of this coverage. You will be notified of the cost of continuation coverage when you are notified of your rights. If you do not choose continuation coverage, your coverage will stop.

If a member has a newborn child, adopts a child or has a child placed with him or her for adoption (for whom the member has financial responsibility) while his or her COBRA continuation coverage is in effect, he or she may add this child to his or her coverage. The Fund Office must be notified, in writing, of the birth or placement to add the child to a member's coverage.

COBRA Continuation Summary

Reason for loss of *coverage:	COBRA Continuation for:	Maximum length of COBRA coverage:
<p>You terminate employment or reduce hours</p> <p style="padding-left: 40px;">If another qualifying event occurs during COBRA Continuation coverage*</p> <p style="padding-left: 40px;">If you or one of your dependents is totally disabled at the time of coverage loss or within 60 days*</p>	<p>For you and/or your dependents</p> <p>For your dependents</p> <p>For dependents</p>	<p>18 months</p> <p>See the other reasons for loss of coverage below. Months shown include the total length of COBRA coverage.</p> <p>An additional 11 months (total of 29 months)</p>
Child no longer meets definition of dependent	For your child	36 months
Legal separation or divorce	For your spouse	36 months
Spouse becomes eligible for Medicare coverage	For your spouse	36 months
You die	For your dependents	36 months

* For coverage to continue, the Fund Office must be notified before the 18-month period ends and within 60 days of the date the Social Security disability determination is issued. Proof of the Social Security Administration's determination of disability must be given. The cost of any extended coverage will be higher than that of continued coverage.

COBRA coverage will end if:

- you or your dependents become covered under another group health care plan with similar coverage;
- you or your dependents become eligible for Medicare;
- the plan is no longer provided by the Midwest Operating Engineer Health and Welfare Fund;
- or
- you or your dependents fail to make the required contribution within 30 days after it is due.

Survivor Benefits

If you die, your surviving spouse may elect to continue coverage in lieu of COBRA by making coverage payments at the monthly rate specified by the Board of Trustees. Your surviving spouse may continue coverage for him or herself and all Dependent children who were covered under the Plan on the day before your death. Disability, death and accidental dismemberment benefits are not available to survivors.

For your surviving spouse to be eligible:

- you must have been eligible under this Plan at the time of your death, and
- you must have been eligible under this Plan for at least ten years (40 Benefit Quarters).

Your dependents' eligibility will end on the earliest of the following:

- the date the required self payment is not made;
- the date your spouse remarries;
- the date a child no longer meets the definition of a Dependent;
- your spouse's death;
- when your spouse or Dependent child becomes entitled to coverage under another group policy or plan;
- when your spouse establishes permanent residence outside the continental limits of the United States.

In addition, active coverage will end and retiree coverage will begin when you would have reached normal retirement age and if your spouse and child(ren) are still covered under the plan at the time.

Survivor Benefits coverage is in lieu of COBRA and runs concurrently with your right to COBRA. If the surviving spouse elects this benefit and loses eligibility, as 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.

Certificate of Coverage

When your coverage ends, you will be provided with a certificate of coverage shortly after you notify the Fund Office that you or your dependents' coverage ended. The certificate will specify the length of time you were covered under the Plan and additional information required by law. This may help reduce or eliminate any pre-existing condition limitation under a new group medical plan. In addition, a certificate will be provided within 45 days after receipt of a request for such certificate that is made within two years after coverage under the Plan ends.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation, or a paternity dispute. The Fund Office will notify affected employees and alternate recipients if a QMCSO is received. You can receive a copy of the Plan's procedures for handling QMCSO's at no cost, by calling the Fund Office.

Family and Medical Leave

Under the Family and Medical Leave Act of 1993, you may qualify to take up to 12 weeks of unpaid leave for a serious illness, to care for your newborn child or newly adopted child, or to care for your seriously ill spouse, parent, or child. If the Family and Medical Leave Act applies to your employer (employers with less than 50 employees within a 75-mile radius are exempt), it requires your employer to maintain your health coverage for the length of your leave for up to 12 weeks, as if you were actively at work. The Act also states that if you take a family or medical leave, you cannot lose any benefits accrued before the leave.

The Fund will grant eligibility for a family or medical leave and maintain your current eligibility status for the duration of the leave, provided your employer properly grants the leave of absence under the Federal law and makes the required contributions to the Fund on your behalf.

When You Retire

Normally, coverage stops when you retire. However, you may be able to continue medical (including prescription drug) and dental benefits for yourself and your eligible dependents under the Retiree Program by making the required coverage payments. You can not continue coverage if you have elected Medicare Part C coverage. See page 21 for retiree eligibility.

Surviving spouses who are eligible to continue to receive health and welfare benefits do so under the Retiree Plan and may have automatic deductions taken from their monthly pension checks

LIFE 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.

Getting Married

When you marry, your spouse is automatically eligible for coverage under the Plan, but you must enroll your spouse. To enroll your spouse for coverage, call the Fund Office and request an enrollment form.

Complete the necessary information and return it to the Fund Office, along with a copy of your marriage certificate. Coverage for your spouse begins on the date of your marriage.

At this time, you also may want to consider updating your beneficiary information for your Death Benefits.

Adding A Child

Your natural child(ren) will be eligible for coverage on their date of birth, but you must enroll each child. To enroll your child for coverage, call the Fund Office and request an enrollment form. Complete the necessary information and return it to the Fund Office, along with a copy of your child's birth certificate or adoption papers. 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 and the situation meets the Plan requirements. Stepchildren who live in your home are eligible for coverage on the date of your marriage. See the *Dependents' Eligibility* section on page 6 for the requirements for adopted children and stepchildren.

Life Events Can Affect Your Benefits Coverage

Life events may include:

- Marriage
- Birth of a child
- Adoption of a child
- Divorce
- Maximum age of a child
- End of work
- Leave of absence
- Death of a Dependent
- Medical leave
- Military duty
- Retirement
- Death

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.
- You may be able to take an FMLA leave.

You may also be eligible to take a leave of absence under the Family and Medical Leave Act (FMLA) . See page 14 for more information.

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 Benefit Quarter in which the divorce or legal separation is decreed. Your spouse may elect to continue coverage under COBRA Continuation Coverage for up to 36 months (see page 10). 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.

At this time, you may also want to review your beneficiary designations for your Death Benefit.

Qualified Medical Child Support Order (QMCSO)

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for a Dependent child(ren) as determined by a court order 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 employee, if that child is identified as an alternate recipient under a QMCSO. Orders must be submitted to the Plan Administrator who will determine whether the order 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.

Once the Plan Administrator receives a QMCSO, the Plan Administrator 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.

Child Losing Eligibility

In general, your child is no longer eligible for coverage when he or she enters active military service on a full-time basis, reaches the limiting age, or is no longer dependent upon you for support (see page 18). You should notify the Fund Office when your child falls into one of the categories above and loses his or her eligibility.

If Your Child Loses His or Her Eligibility

- Contact the Fund Office immediately.
- Your child may elect to continue coverage under COBRA (see page 10).

If your child is age 19 to 23 and a full-time student, the child's school needs to send a letter to the Fund Office each semester or quarter indicating the child is a full-time student. Otherwise, the Fund Office will assume the child is not a full-time student. To qualify for continued coverage as a full-time student after age 18, the dependent must be an eligible dependent under this Plan at the time they turn 19 years of age.

If your child loses eligibility, he or she may elect to continue coverage under COBRA for up to 36 months (see page 10). 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 Continuation Coverage.

Limiting Age

Under the Plan, the limiting age for your unmarried Dependent child is:

- age 19; or
- age 23, if your child is a full-time student at an accredited school and mainly dependent on you for support and maintenance.

If your child is not capable of self-supporting employment because of a physical handicap or mental retardation, 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.

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 and file a claim for Dependent Death Benefits. See the ***How To File A Claim*** section on page 74 for information on how to file a Dependent Death Benefit claim.

At this time, you may also want to review your beneficiary designations for your Death Benefit.

Becoming Disabled

If you are out of work due to a non-work related disability, you are eligible to receive Weekly Accident and Sickness Benefits from the Plan (see page 19). Benefits continue until you recover or receive 52 weeks of benefits for one period of disability, whichever occurs first.

If you become disabled due to an Injury that is covered by the Accidental Dismemberment Benefit, you may also be eligible for an Accidental Dismemberment Benefit (see page 66).

You will receive hours credit for up to 17 weeks while you are on occupational or non-occupational disability. After that, you may continue coverage for up to four (4) consecutive contribution Quarters if you make self-payments. After this time, you may continue your coverage through COBRA. See the sections on COBRA Continuation Coverage (see page 10) for more information.

Taking A Leave Of Absence

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- the birth of a child or placement of a child with you for foster care or adoption;
- the care of a seriously ill spouse, parent, or child; or
- your serious illness.

If you and your spouse both work for the same Employer, you and your spouse are eligible for a combined total of 12 weeks of leave during a 12-month period. (However, a family and medical leave of absence is not granted to care for a parent-in-law.)

The Fund will maintain your prior eligibility until the end of the leave, provided your Employer properly grants leave under federal law and makes the required notification and payment to the Fund.

You may be required to provide:

- 30-day advance notice of the leave, if possible;
- medical certifications supporting the need for a leave;
- second or third medical opinions and periodic recertification (at your Employer's expense) and periodic reports during the leave regarding your status and intent to return to work.

Your leave will end on the earlier of your return to work or 12 weeks. If you do not return to work within 12 weeks, you may qualify for COBRA Continuation Coverage (see page 10).

Taking A Military Leave

If you or your dependent go into military service (active duty or inactive duty training) for up to 31 days, your health care coverage will continue if you make the required coverage payment. If you or your dependent go into military service for more than 31 days, you may continue your coverage by making the required coverage payment for up to 18 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Your coverage will continue to the earliest of the following:

- the date you or your Dependents do not make the required coverage payments within 30 days of the due date;
- the date you reinstate your eligibility for coverage under the Plan;
- the end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- the last day of the month after 18 consecutive months; or
- the date the Fund no longer provides any group health benefits.

You need to notify the Fund Office in writing when you enter the military. For more information about coverage payments under USERRA, contact the Fund Office.

If you do not continue coverage under USERRA, your coverage will end immediately when you enter active military service. Your Dependents will have the opportunity to elect COBRA

Continuation Coverage. When you are discharged or released from military service:

- that lasted less than 31 days, you have until the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service to return to work for a Contributing Employer;
- that lasted more than 30 days but less than 181 days, you have up to 14 days to return to work for a Contributing Employer;
- that lasted more than 180 days, you have up to 90 days to return to work for a Contributing Employer; or
- you are hospitalized or convalescing from a Sickness or Injury incurred in military service, you have until the end of the period that is necessary for you to recover to return to work for a Contributing Employer.

Reemployment

Following your discharge from military service, you may be eligible to apply for reemployment with your former Employer in accord with USERRA. Such reemployment includes your right to elect reinstatement in any existing health care coverage provided by your Employer.

An eligible dependents coverage may be reinstated if within 90 days following discharge and as of the date of reinstatement, he meets the definition of a dependent of this plan.

If your Employer reports your return to the Fund Office during the USERRA required time period, your eligibility and your Dependents' eligibility *will be reinstated on the day you return to work.*

The Fund will maintain your prior eligibility status until the end of the leave, provided your Employer properly grants leave under federal law and makes the required notification and payment to the Fund.

In The Event Of Your Death

If you die while eligible for coverage under the Fund, your beneficiary will receive a Death Benefit. See pages 21 and 65 for more information about the Death Benefit provided by the Plan.

Your spouse and children may be able to continue their health care coverage under Survivor Benefits or COBRA. See page 13 for Survivor Benefits Information and page 10 for COBRA.

When You Retire

When you retire, you may be eligible to continue coverage for yourself and your Dependents under the retiree plan. If you are eligible for Medicare, the PPO network is not available to you. Weekly Disability, Death, and Accidental Dismemberment benefits under this plan are not available to members in retired status. In general, you will qualify for retiree coverage if:

- at the time you retire, you are eligible to receive benefits from this plan; AND
- you are 100% vested and have ten Pension Credits in the Midwest Operating Engineers Pension Plan; AND
- you have ten years of service with this plan; AND
- you are retiring from active covered employment; AND
- you are receiving normal, early, or disability retirement benefits under the Midwest Operating Engineers Pension Fund, or under a pension plan created pursuant to a collective bargaining agreement under which this Welfare Plan was adopted, requiring Employer Contributions to be made to the Midwest Operating Engineers Health and Welfare Fund.

It is very important that you apply for and choose this coverage before you retire. You must make the required payment for this coverage before the first benefit quarter after you retire or in which you failed to maintain active coverage (due to insufficient hours in the related eligibility quarter). If you do not apply at this time or if you fail to make the required payment on time, coverage will end. Coverage will also end if you do not pay the future coverage payments on time. Once your coverage terminates, it cannot be reinstated.

You must elect coverage for your dependents at the time you retire. If you do not, you will not be able to add dependent coverage at a later date unless you acquire new dependents later such as through marriage or birth. For coverage after you retire, your dependents must continue to meet the same eligibility requirements as an active employee's dependents, described on page 6).

If you elect to cover only yourself when you first retire and then acquire a dependent, you may add your new eligible dependent within six months of acquiring the dependent. Coverage will begin on the first day of the benefit quarter after the application is received. You will need to pay the proper self-payment amount. If you were covered prior to January 1, 2000, you would have had to make such application by July 1, 2000.

Once you retire, you remain in retired status even if you subsequently return to covered employment. This means that you must continue making the required self-payments in order to maintain your eligibility for the Retiree Program.

Retiree coverage is not available if you have Medicare Part C coverage.

SCHEDULE OF BENEFITS

All benefits are subject to the maximum plan benefit, reasonable and customary determination (or negotiated fee amounts for PPO provider services), pre-existing condition limitations and any special limits noted. Charges that exceed the reasonable and customary amount or other plan limitations will not be considered eligible expenses in determining plan benefits.

Reasonable and Customary: 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

COMPREHENSIVE MEDICAL BENEFITS	
Calendar Year Benefit Maximum	\$ 50,000 + balance of \$750,000 Supplemental Lifetime Fund
Calendar Year Deductible	\$300 per person (limited to \$700 per family)
Calendar Year Out-of-Pocket Maximum	\$2,500 per person (limited to \$6,000 per family)
<i>The following benefits are payable at 100% and are not subject to the deductible *.</i>	
Benefit	Special Limits
Routine Physical Exam	For members and their dependent spouses, up to \$350 per person in a Calendar Year.
Well-Baby Care	For eligible newborn dependent children to age 2, payable up to \$2,000 lifetime.
<i>The following benefits* are payable as follows:</i>	
<i>In-Network (PPO Provider): 90%</i>	
<i>Out-of-Network (Non-PPO Provider): 80%</i>	
<i>Benefits are payable once the calendar year deductible is satisfied, and are payable at 100% after the out-of-pocket limit is met. See page 32 for more information about PPO providers.</i>	
Benefit	Special Limits, If Any
Hospital Room and Board and Miscellaneous Expenses	Private room only if medically necessary (i.e. contagious diseases).

* Eligible expenses must be medically necessary and are subject to reasonable and customary limits.

Outpatient Surgical Charges	For outpatient surgery, charges for surgical supplies are included in the physician's fee.
Physician's Care	
Pre-Admission Testing	Within 14 days of hospitalization.
Second Surgical Opinion	From a Board-Certified surgeon.
MRIs	Payable at 100% when services are received through the Medlink Health Care Network call (888) 558-0680. Payable at the in-network level when services are received through <i>BCBS</i> . See page 32 .
Kidney Dialysis	
Chemotherapy/Radiation Therapy	
Hepatitis C	Up to \$40,000 when approved by the Plan for initial course of treatment up to 12 months, then subject to the prescription drug calendar year maximum of \$20,000.
Organ/Tissue Transplants	\$300,000, including:
Lifetime Transplant Maximum	
Organ/Tissue Procurement	up to \$25,000
Transportation & Lodging	up to \$10,000
Private Nursing Care	up to \$10,000
Convalescent Care	Coverage limited to 45 days per spell of illness, must be within 30 days of hospital stay.
Continuing Care	When approved by Case Manager only.
Chiropractic Care	Only when medically necessary and performed by a chiropractor. Subject to a maximum of 24 manipulations per a calendar year with a maximum of \$60 per manipulation. No coverage for children under the age of 5. No coverage for routine chiropractic manipulations.
Outpatient Therapy	When approved by Case Manager only.
Foot Orthotics	When prescribed by a medical doctor and custom fitted \$300/year maximum and \$1,500 lifetime maximum
Cochlear Implants	For dependent children between the age of 2 and 19. When approved by the Case Manager and a network facility is used.
Mental Health and/or Substance Abuse Treatment	You must use a ComPsych provider; otherwise, charges are not covered.
Inpatient	

In-Network Only	Coverage limited to 30 days per lifetime
Outpatient In-Network Only	Coverage limited to 60 visits per lifetime When approved by Case Manager only.

The following special coverages are payable at 80% and are not subject to the calendar year deductible unless otherwise noted.*

Benefit Medical Equipment	Special Limits If you pre-certify Durable Medical Equipment. Without certification, payable at 50%. Electronic or mechanized wheelchairs are limited to a maximum of \$15,000
Treatment for Congenital Neurological Diseases for dependent child to age 19 including physical, occupational & speech therapy.	<i>Subject to calendar year deductible.</i> Limited to \$5,000 per calendar year when approved by a Case Manager only.

The following special coverages are payable at 50% and are not subject to the calendar year deductible unless otherwise noted.

Benefit Temporomandibular Joint Syndrome Orthodontics (TMJ)	Special Limits Maximum lifetime benefit for each eligible person of \$2,500.
Orthoptic Training	<i>Subject to the calendar year deductible.</i> For dependent children only, up to age 10. Limited to 40 visits per lifetime. Must be referred by an MD or DO.
Rehabilitation Speech Therapy for a child age 2 through 5	<i>Subject to calendar year deductible</i>

* Expenses must be medically necessary and are subject to reasonable and customary limits.

Prescription Drug Program									
The Prescription Drug Program covers eligible prescription drug expenses when you fill your prescription at the Midwest Benefit Pharmacy or at any network pharmacy for emergency prescriptions only. The Program's benefits are highlighted below and are explained in more detail beginning on page 46.									
Calendar Year Maximum	\$20,000 per person								
At the Midwest Benefit Pharmacy: Walk in, call or mail									
M, Tu, W, F	8:00 a.m. to 6:00 p.m.								
Th	8:00 a.m. to 7:00 p.m.								
Sat	8:00 a.m. to 12:00 p.m.								
<ul style="list-style-type: none"> ➤ Up to a 30-day supply ➤ Up to a 60-day supply ➤ Up to a 90-day supply <p>Dispensing Limitations</p> <ul style="list-style-type: none"> ➤ New Medications ➤ Refills ➤ Schedule II Medications ➤ Diabetic Test Strips & Lancets <p>Mail Order Service</p>	<p>Co Payment Amount:</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Generic</u></th> <th style="text-align: left;"><u>Brand Name</u> **</th> </tr> </thead> <tbody> <tr> <td>You pay \$5</td> <td>You pay \$10</td> </tr> <tr> <td>You pay \$10</td> <td>You pay \$20</td> </tr> <tr> <td>You pay \$15</td> <td>You pay \$30</td> </tr> </tbody> </table> <p>Up to a 30-day supply Up to a 90-day supply Up to a 30-day supply Up to a 100-unit (30-day) supply</p> <p>The Pharmacy will mail your prescription to your home via First Class Mail, Certified Mail or UPS. See page 47 for more information.</p>	<u>Generic</u>	<u>Brand Name</u> **	You pay \$5	You pay \$10	You pay \$10	You pay \$20	You pay \$15	You pay \$30
<u>Generic</u>	<u>Brand Name</u> **								
You pay \$5	You pay \$10								
You pay \$10	You pay \$20								
You pay \$15	You pay \$30								
At Any Network Pharmacy (emergency medication up to a 15-day supply)	Plan reimburses you for 80% of covered prescriptions.								
At Any Non-Network Pharmacy	Not covered.								
At Any Convalescent/Nursing Home	Plan reimburses you for 50% of covered prescriptions.								

**Unless your physician specifies "do not substitute" on your prescription, all scripts will be filled with generics, whenever a generic substitute is available*

*** If you purchase a brand name medication that has a generic alternative available, you will pay the difference in price for the medication in addition to the brand name co-payment amount.*

Dental Plan	
<p>The Plan's benefits are based on a Maximum Allowable Fee Table . Your dental benefits are highlighted below and are explained in more detail beginning on page 55. Only eligible expenses that are medically necessary are covered.</p>	
<p>Calendar Year Maximum Benefit</p> <p>Dental Copayment</p> <p style="padding-left: 20px;">Preventive Services</p> <p style="padding-left: 20px;">Basic and Restorative Services</p> <p>Orthodontics (children under age 19)</p> <p>Dental PPO Network</p>	<p>\$1,000 per person</p> <p>Plan pays 100% (not subject to Maximum Allowable Fee)</p> <p>Plan pays 70%</p> <p>Plan pays 50% up to a lifetime maximum benefit amount of \$1,500 per covered child. Treatment plan should be submitted prior to receiving treatment.</p> <p>You can save money on your out-of-pocket dental care costs when you go to a Guardian Preferred Provider Organization (PPO) Network dentist. Call 1-888-600-2580 for a network dentist near you. See page 56 for more information.</p>
Family Supplemental Benefit	
Family Calendar Year Maximum	\$1,500
NON-OCCUPATIONAL WEEKLY DISABILITY BENEFIT (Active Employees Only)	
Benefit Amount	\$250 per week for up to 52 weeks
When Benefits Begin	First day of accident or illness, provided disability lasts at least eight days.
DEATH BENEFIT	
Benefit Amount	
Active Employees	\$30,000*
Eligible Dependents	\$ 2,000
*Limited to \$7,500 for Active Employees of the City of Chicago.	
ACCIDENTAL DISMEMBERMENT BENEFIT (Active Employees Only)	
Benefit Amount	\$5,000 or \$1,000 based on type of loss

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).
- For services rendered by an eligible provider.
- For treatment that is medically necessary and prescribed by a legally qualified physician and is non-experimental and non-investigational.
- Subject to the pre-existing condition limitation.

How The Plan Works

Pre-existing Condition Limitation

A pre-existing condition means a condition for which medical advice, diagnosis, care or treatment was provided within 6 months before the date you first became eligible for medical benefits under this plan. The benefit of an eligible person with a pre-existing condition will be subject to the following limitation:

Benefits for that condition or any related condition will be limited to \$15,000 for each covered person (including eligible dependents) for a period of 12 months immediately

following the date you first become eligible for medical benefits under the plan.

Pregnancy is not considered a pre-existing condition. Contact the Fund Office if you have any questions as to whether this limitation applies to your benefits. If you are a new employee, be sure to obtain a Certificate of Creditable Coverage from your prior insurer to possibly waive the pre-existing condition limitation.

The Deductible

Each year, before the plan pays anything for most covered 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:

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:

Date of Medical Service	Covered Charges for:		
	You	Your Spouse	Your Child
January	\$300		
March		\$500	
April			\$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 January, you pay \$300 out of your own pocket, and the full amount is credited toward your individual deductible.
- In March, you pay \$300 of the \$500 to satisfy your spouse's individual deductible. Of the

remaining \$200, you pay 10%, or \$20. The plan pays 90%, or \$180.

- In April, you pay only \$100 toward your child's individual deductible before benefits begin for your child. This is because your family's payments toward the individual deductibles will have reached the \$700 family deductible maximum. Of the remaining \$300, you pay 10%, or \$30. The plan pays \$270.

Carryover

Beginning in 2002, you may carryover your deductible from the last three months of the previous year. For example, if you had no medical claims until November and then met your individual \$300 deductible, you wouldn't need to satisfy your deductible for the following year.

Copayment

After satisfying the deductible, you and the plan share responsibility for additional eligible medical expenses. Generally, the plan pays 90% (for in-network expenses) or 80% (for out-of-network expenses). You pay the remaining cost.

Your copayment can be different, depending on the specific plan benefit. For example, the plan pays 100% (with no deductible) for some covered expenses; other covered expenses are payable at 50%.

PPO Providers

You have access to preferred provider organization (PPO) hospitals and doctors under the plan. PPO providers offer discounts on services to you and your eligible dependents. When you use a PPO provider (or 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 a *non-network* provider, your out-of-pocket costs may be higher because your care costs more. See page 32 for more information on PPO networks.

Reasonable and Customary Limits

Non-network provider services are subject to the plan's reasonable and customary limits. An expense is considered reasonable and customary 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 a non-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.

If you go to a network provider and are charged more than the negotiated fee amount for any given service, you will **not** be responsible for amounts above the negotiated fee amount. Reasonable and customary limits do not apply to network provider services.

Annual Out-of-Pocket Maximum

Once your payments toward the annual deductible and copayments for eligible medical charges reach the annual out-of-pocket maximum of \$2,500 per person (\$6,000 per family), the plan will usually pay 100% of most eligible expenses for the rest of the calendar year. Expenses that are not covered under the Plan do not apply toward the out-of-pocket limit. Also, plan benefits payable at 50% and any expenses in excess of specific benefit maximums are not considered in determining the out-of-pocket limit. Benefits payable at 50% or 80% (that are not subject to the calendar year deductible) continue to be payable at 50% or 80% (not 100%) even after the calendar year out-of-pocket maximum is reached. See items listed under “Special Coverages” on page 42.

Annual means from January 1 through December 31 of any year.

\$50,000 Maximum Yearly Benefit/ \$750,000 Supplemental Lifetime Fund

The maximum medical benefit payable for an eligible person under the plan is \$50,000 in a calendar

year. In addition to this Maximum Yearly Benefit, each eligible individual also has a nonrenewable *Supplemental Lifetime Fund*. This is a lifetime amount of \$750,000 for each eligible person that is available to supplement the Maximum Yearly Benefit. All paid medical benefits, including special coverage benefits, are considered in determining the yearly and Supplemental Lifetime Fund. Here is an example of how this works:

During calendar year 2001, the plan pays \$150,000 in medical benefits for you. The first \$50,000 is your Maximum Yearly Benefit. The remaining \$100,000 is deducted from your Supplemental Lifetime Fund. Beginning in calendar year 2002, your Supplemental Lifetime Fund is now \$650,000 and your Maximum Yearly Benefit is \$50,000. If an eligible participant's Supplemental Lifetime Fund becomes depleted, the plan will continue to pay up to the \$50,000 Maximum Yearly Benefit on his or her behalf each calendar year.

Using PPO Networks

NOTE: If you are retired and eligible for Medicare, the benefits described in this section do not apply to you. In that case, the Plan's copayment is 80%, coordinated with Medicare.

As an eligible participant of the Midwest Operating Engineer Health and Welfare Fund, you can go to **any medical provider** for your health care needs. However, you'll receive a higher level of benefits (typically 90%) and save money on your covered health care expenses when you go to a doctor or hospital that belongs to the preferred provider organization (PPO) network available to you:

PPO Network:

The Blue Cross/Blue Shield of Illinois
PPO Network

The Blue Cross/Blue Shield
Blue Card Program

The Medlink Health Care Networks

Available to:

For participants and/or dependents who
live in the Illinois area

For participants and or dependents who
live or are traveling outside of the Illinois
area

If you need an MRI or CT Scan, you may
use any of these three networks.

These PPO networks consist of doctors and hospitals that 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.

PPO Networks You Must Use For Coverage

Whether you use in-network or out-of-network doctors, certain situations will require the use of other PPO networks as shown below.

FOR THIS SITUATION	YOU MUST CONTACT THIS PROVIDER	TELEPHONE NUMBER
You need precertification and case management services for a covered transplant	Fund Office	(708) 579-6600
You need Mental Health or Substance Abuse Treatment precertification	ComPsych	(888) 327-4315

Your Identification (ID) Card

The Welfare Fund ID card indicates that eligible members have access to the Blue Cross/Blue Shield of Illinois PPO and outside of Illinois the Blue Cross/Blue Shield Blue Card Program. Whenever you visit a Blue Cross/Blue Shield provider, show your ID card. Your health care provider will file your claim for you, and your claims will be processed as quickly as possible. Your Blue Cross/Blue Shield provider should not request payment at the time of service other than your office copayment.

Your Guide to PPO Care

The following guide is a quick reference you can use when you need care.

When you need...	
Any type of medical care	<p>You decide each time you need treatment whether to go in-network or out-of-network.</p> <p>When you go in-network, you'll use a doctor and/or hospital that belongs to the PPO network available to you:</p> <ul style="list-style-type: none">➤ Blue Cross/Blue Shield of Illinois PPO; or➤ Outside Illinois – Blue Cross/Blue Shield Blue Card program. <p>Once you satisfy the annual deductible, the Fund pays 90% of most covered in-network services.</p> <p>Of course, you may go to any provider and receive out-of-network benefits for covered services. Once you satisfy the annual deductible, the Fund pays 80% of most covered out-of-network services.</p> <p>If your payments toward covered expenses reach the out-of-pocket maximum, the plan pays 100% of expenses for most covered services for the rest of that calendar year.</p>
When your doctor recommends hospitalization or	If your doctor does not belong to one of the Fund's PPO networks, ask if one of the PPO network hospitals could be used for treatment. PPO hospital listings are available at the Fund Office.

surgery	PPO doctors should automatically direct you to a PPO network hospital for treatment, when appropriate.
Care while traveling outside of the Illinois area	BC/BS Blue Card PPO providers are located all over the country. To receive in-network benefits, you can call (800) 810-2583 or log on to www.bcbsil.com to find provider near you.
Care for dependents who are away at school	Find out if medical treatment is available through the school's student health service or infirmary. The cost for many services may be included in tuition and fees.
Additional information about the PPO networks	<p>If the student lives outside of the Illinois area, a BC/BS Blue Card PPO provider may be available. Call (800) 810-2583 or log on to www.bcbsil.com to see if a PPO provider is available in the student's area.</p> <p>Blue Cross/Blue Shield of Illinois: (800) 810-2583</p> <p>Medlink Health Care Networks: (888) 558-0680</p> <p>Fund Office: (708) 482-7300 (800) 323-3060</p>

Covered Medical Expenses

The Plan covers eligible expenses only up to the reasonable and customary limits and only if the services and supplies are medically necessary. An expense is reasonable and customary if:

- For PPO network providers, the charge is agreed upon between the PPO and the Plan, or
- For non-network providers, the charge is the lowest of:
 - the usual and customary charge for the same or similar service or supply in the same or similar geographic area; or
 - the prevailing charge of 90% of the health care providers in the same or similar geographic area for the same or similar service or supply; or
 - the health care provider's actual charge.

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 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.

See the Schedule of Benefits on page 23 for coverage levels and limitations for the services described in this section.

Wellness Benefits

- **Routine Physical Examination Benefit** - covers expenses for services that are part of a routine physical exam (including work physicals and baseline mammograms). Benefits are limited to \$350 during a Calendar Year. Only active and retired (effective January 1, 2001) employees and their dependent spouses are eligible for this benefit.
- **Well Baby Care Benefit** - covers expenses for hospital charges and physician's fees for a well newborn child during hospital confinement while the mother is also confined for the birth of the child. The benefit also covers pediatric visits, immunizations, vaccinations and laboratory services during the first 24 months following birth, up to a maximum dollar benefit of \$2,000. Plan coverage is not available to a newborn child of an individual covered as a participant's dependent child.

Basic Benefits: Deductibles And Out-Of-Pocket Limits Apply

- **Hospital Benefit**

- covers expenses for room and board at the actual semi-private rate (or the actual room and board charge for the intensive care unit or private room if the disease is contagious), if required for hospitalization or treatment due to a non-occupational injury or illness.
- covers miscellaneous expenses 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 certified as medically necessary.

- Expenses for **take-home drugs** following hospital care.
- **Surgical Charges Benefit** - covers expenses for a medically necessary surgical procedure performed by an eligible service provider under the plan while confined as an inpatient at a hospital, or on an outpatient basis in an ambulatory Surgery Center or Hospital Day Care Surgery Program. Eligible expenses include the surgeon's fees as well as other related surgical expenses. As with all plan benefits, eligible expenses for surgeon's fees are limited to usual, reasonable and customary limits. For outpatient surgery, expenses for surgical supplies are included in the physician's fee.

Under the Women's Health and Cancer Rights Act of 1998, benefits for reconstructive breast surgery following a mastectomy are provided on the same basis as other surgical procedures covered by the Plan and include reconstruction of the breast on which a mastectomy is

performed, reconstructive surgery on the other breast to produce a symmetrical appearance, prosthesis, and physical complications of any stage of mastectomy, including lymphedemas.

- **Surgical Opinion Benefit** - covers expenses incurred in obtaining a second opinion. If your doctor has recommended surgery and you wish to have a second opinion, the plan will cover the cost of this second opinion, including any laboratory or X-ray fees, provided the second opinion is from a Board Certified Surgeon.

If the Board Certified Surgeon you go to does not recommend the surgery, you can get a third opinion, also from a Board Certified Surgeon, and the plan will cover the expenses associated with this.

Once you receive a second opinion, the choice of having surgery is up to you. All surgery is risky, and getting a second opinion helps you decide if the operation is really necessary or if there is another form of treatment available.

If you want a second opinion and don't know which doctor to go to, call your local medical society or the American Medical Association.

- **Physician's Care Benefit** - covers expenses for doctors visits and consultations - while you are hospitalized or on an outpatient basis.
- **Diagnostic X-rays and Laboratory Benefit** - covers expenses for medically necessary tests.
- **Pregnancy Care Benefit** - covers reasonable and customary expenses that are pregnancy-related and are paid under the plan on the same basis and subject to the same limitations as any other sickness. Plan coverage is available to a newborn child of a participant only.

Group health plans and health insurance issuers generally may not, under Federal law, 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. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

The plan also covers reasonable and customary expenses related to certain legally performed abortions once in a 12-month period. Evidence of medical necessity for abortion must be provided in the second or third trimester of pregnancy.

- **MRI Benefit** - covers expenses for MRIs and CAT scans. If you precertify through and use a Medlink Health Care Network provider, these expenses are covered at 100%. If you use a Blue Cross Blue Shield provider these expenses are covered at 90%. If you do not use these network providers, these expenses are covered at 80%.
- **Physical Therapy** – when approved by the case manager.
- **Kidney Dialysis Benefit** - covers expenses for dialysis administered on an out-patient basis, including the outpatient doctor or technician charges, unless the charges would have been covered under Medicare. (Contact the Fund Office if you have a question about Medicare benefits.)
- **Radiation Therapy Benefit** - covers expenses for treatment administered on an outpatient basis, including the rental or use of radioactive substances, and the outpatient doctor or technician charges.
- **Chemotherapy Benefit** - covers expenses for treatment administered on an outpatient basis, including the outpatient doctor or technician charges, and chemotherapy drugs.
- **Hepatitis C** - covers the initial course of treatment when recommended by a physician and

- **Allergy Injections Benefit** - covers expenses for allergy medications and their administration.

- **Prostheses and Support Devices Benefit** - covers expenses for prostheses and supportive devices including Colostomy bags and necessary accoutrements required for attaching. We recommend that you request verification from the Fund Office that the device is an eligible expense under the plan. Expenses for foot orthotics are covered when prescribed by a medical doctor and custom-fitted. Benefits for foot orthotic expenses are limited for each eligible person to \$300 per calendar year and \$1,500 per lifetime.

- **Convalescent Care Benefit** - covers expenses for up to 45 days for each period of convalescence, provided it is recommended and supervised by a doctor, is for the same condition, and begins within 30 days after discharge from a hospital.

- **Continuing Care Benefit** - in certain circumstances, expenses for transitional continuing care may be covered, for up to a maximum of 90 days, if that care meets the Fund's case management guidelines. An example of continuing care would be medically necessary care following hospitalization and/or major surgery. If eligible, the benefit also covers expenses such as hospice and home health care. You must contact the Fund Office to find out whether plan benefits will be payable.

Please contact the Fund Office if you have any questions about the qualifications of your provider or the types of expenses covered by the plan.

- **Mental Health and Chemical/Substance Abuse Benefits** - (you must precertify treatment with ComPsych) your plan provides you and your eligible dependents with coverage for costs associated with psychiatric and/or chronic alcoholism and drug abuse

treatment, provided such services are rendered by a ComPsych provider (you must precertify treatment with ComPsych). For each covered person, the plan provides up to the maximum benefits stated in the Schedule of Benefits (see page 23).

- **Member Assistance Program (MAP)** - provides confidential assessment and referral services for you and your eligible dependents with personal issues.
- **Organ Transplant Benefits** - your plan provides coverage for medically necessary services and supplies that have been **precertified** through the Fund for the following transplant procedures through Blue Cross/Blue Shield Center of Excellence Network only:
 - bone marrow transplants
 - heart,
 - heart, lung
 - liver
 - kidney
 - cornea transplants.

The plan **does not** cover:

- transplants paid for by governmental foundation or charitable grants; or
- "sold organs" - the amount charged to purchase an organ.

The lifetime aggregate maximum benefit payable for these procedures is \$300,000 for each eligible person. Note that an important feature of the transplant benefit allows you to use the \$300,000 maximum benefit also to cover the medically necessary services incurred by the transplant donor if the donor does not have medical coverage for the eligible transplant expenses. The following limits also apply:

- \$20,000 for organ or tissue procurement,
- \$10,000 for transportation and lodging; and
- \$10,000 for private nursing care.

Physical therapy - covered on an outpatient basis when ordered by a doctor as a result of an illness or injury, including the therapy charges and doctor or technician charges. Physical therapy in excess of six visits must be pre-approved by a case manager. (Note that therapy for comfort only, maintenance therapy and vocational therapy is not covered.)

Chiropractic Care - covered when medically necessary and performed by a licensed chiropractor.

The following limits apply

- maximum of 24 manipulations per year
- maximum allowable amount of \$60 per spinal manipulation
- no coverage for children under the age of 5

Special Coverages

The following special coverages under the plan provide benefits equal to 50% or 80% (see the Schedule of Benefits on page 23) for certain eligible expenses. Unless otherwise noted, benefits are not subject to the annual deductible. Payments toward these expenses do not apply to the out-of-pocket limit and are never covered at 100%. The amounts paid for these special coverages are considered in determining your annual maximum and lifetime maximum benefits.

- **Medical equipment** that is purchased, rented or leased, if it is prescribed by a doctor for a specified amount of time. Medical equipment must be necessary for the medical treatment of a condition and pre-certified. If you do not pre-certify, the plan will only cover 50% of the charges. It includes such items as hospital beds, wheelchairs, hemodialysis equipment, intermittent positive pressure breathing machines, walkers, crutches, canes, concentrators, oxygen walker units, and percussors. Diabetic test strips and lancets are covered by the plan's prescription drug benefits. For purposes of determining eligible plan expenses, the cumulative cost of equipment rental or lease is limited to 80% of 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.

- **Outpatient physical, occupational and speech therapy for congenital neurological diseases for dependent children** up to age 19, up to a calendar year maximum of \$5,000, if approved by Case Manager.
- **Speech therapy** on an outpatient basis for eligible dependents, age two through age five, for eligible speech therapy expenses to a maximum lifetime benefit of \$2,500 for each dependent child.
- **Rehabilitation speech and occupational therapy for a child** age two through five, subject to the calendar year deductible.
- **Expenses For Temporomandibular Joint Dysfunction (TMJ)** - orthodontic expenses for TMJ care will be reimbursed for treatment up to a maximum benefit of \$2,500 for the lifetime of the patient. Please contact the Fund Office for a claim form. The dentist must provide a narrative explaining the patient's TMJ history and care.
- **Expenses for orthoptic training** (eye muscle exercise) for eligible dependent children up to age 10, limited to a maximum of 40 visits per lifetime.

Exclusions

No medical benefits shall be payable for:

- Cosmetic Surgery or Treatment, except for treatment of an accidental injury occurring while covered by the Plan or for a congenital anomaly in Dependent children.
- Reversal of sterilization, hormone therapy, artificial insemination, invitro 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.
- Routine foot care such as removal of warts, 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, except as specifically stated otherwise.
- Radial keratotomy (RK), photo refractive keratectomy (PRK), laser in situ keratomileusis (LASIK) or other procedures for surgical correction of myopia and/or other refractive errors.
- The purchase, servicing, fitting and/or repair of hearing aid devices, including but not limited to hearing aids and cochlear implants. Except for children between the age of 2 and 19.
- Diagnosis and treatment of refractive lenses, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies.
- 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 a Covered Medical Expense and the provider of the service meets the definition of Eligible Provider on page 86.
- Any operation or treatment for teeth and gums, except:
 - Tumors;
 - orthodontia, except under special circumstances of disease or injury;
 - accidental Injury to teeth which occurs while the person is covered under this Plan, provided the treatment or diagnostic x-rays are received within 90 days of the Injury.
- Chelation therapy, except in cases of heavy metal poisoning.
- Any expenses that are not Covered Expenses.
- Telephone consultations.
- Weight loss programs such as Jenny Craig, Nutri-Systems, etc., including nutritional counseling and prescription drugs related to weight loss programs.

- Treatment for substance abuse or mental and nervous disorders other than as specifically covered on page 41.
- Wigs or toupees, hair transplants, hair weaving or any drug in connection with baldness.
- Illness or Injury that is related to any occupation or employment for wages or profit.
- Care and treatment that is not Medically Necessary.
- Charges which exceed the maximum benefits allowed under the Plan;
- Transplants which are not listed on page 41;
- Treatment or medication which is Experimental or Investigational; and
- Expenses specified as not payable in General Exclusions on page 67.

PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program covers eligible prescription drug expenses when you fill any of your prescriptions at the Midwest Benefit Pharmacy or fill an emergency medication at a network pharmacy.

The Midwest Benefit Pharmacy Program

Prescription drug benefits are provided to eligible participants and their dependents through the Midwest Benefit Pharmacy Program. Benefits under this Program are available when you fill your prescription at the Midwest Benefit Pharmacy only, except for limited emergency prescriptions described on page 49.

There is no deductible to satisfy before benefits for covered prescription drugs begin. For generic prescriptions you pay a \$5 co-payment for up to a 30 day supply. For brand-name prescriptions, you pay a \$10 copayment for up to a 30-day supply. If you purchase a brand name medication that has a generic equivalent you will pay the difference in the cost of the medication in addition to your brand name co-payment. The Program covers the rest of the cost.

The Prescription Benefit is limited to \$20,000 per person in prescription drug benefits each Calendar Year (Midwest Benefit Pharmacy and any emergency prescriptions combined).

Note: Prescription drugs used for the treatment of cancer, chemotherapy drugs and supplies and anti-rejection drugs for covered transplants are **not** subject to this maximum and are covered under the Comprehensive Medical Benefit.

Filling Your Prescription

You can fill your prescription in person or by mail. The prescription should specify the quantity at which the prescription is to be filled and directions for use.

To fill your prescription by mail, submit your original written prescription to:

Midwest Benefit Pharmacy

6150 Joliet Road

Countryside, Illinois 60525

To refill a prescription using the Toll Free Automated Refill Line call (866) 850-9310.

Be sure to include the member's social security number or unique member identification number and any required copayment for the prescription. All prescriptions require a copayment.

Copayments for generic vs. brand-name prescriptions are based on the following chart:

	<u>GENERIC</u>	<u>BRAND</u>
Up to a 30-day supply:	\$ 5 copayment	\$10 copayment
31-60 day supply:	\$10 copayment	\$20 copayment
61-90 day supply:	\$15 copayment	\$30 copayment
Diabetic Test Strips & Lancets: (100-unit supply)	\$5 copayment	

Once your prescription has been filled, if you would like to use the overnight UPS delivery, the cost is an additional \$15. Otherwise, prescriptions will be mailed to you by regular mail.

Schedule II medications are treated differently (see page 51).

If you prefer to fill your prescription in person, you may do so. The Pharmacy is open six days a week for your convenience:

Midwest Benefit Pharmacy

6150 Joliet Road

Countryside, Illinois 60525

Monday through Friday: 8:00 a.m. - 6:00 p.m. (Thursdays until 8:00 p.m.)

Saturday: 8:00 a.m. - 12:00 p.m.

Prescription Refills

If your written prescription indicates that refills are available, the Pharmacy will issue you a **refill ticket** when the drug is first dispensed. When it's time to order a refill, mail in your refill ticket to the Midwest Benefit Pharmacy or call the Toll Free Automated Refill Line (866) 850-9310 and follow the simple instructions. When using the Automated system you will need the rx number located on the bottle and the date of birth for the individual your are ordering for. Your prescription will be filled and sent to your home address via First Class Mail, Certified Mail or UPS.

Be sure to check your refill ticket to make sure that the prescription hasn't expired and that there are refills still remaining. If needed, obtain a new prescription from your doctor.

If you submit a new prescription for a drug already on file at the Pharmacy, any refills remaining on the older prescription will no longer be valid. As required by law, the Pharmacy can fill only the most current dated prescription for any medication on file.

Dispensing Limitations

You can receive up to a 90-day supply of a prescription **provided**:

- the prescription had been previously filled at the Pharmacy or another pharmacy, **and**
- your physician indicates on the written prescription that the Pharmacy can dispense up to a 90-day supply of the drug at one time.

Otherwise, the Pharmacy can only dispense up to a 30-day supply per prescription.

If You Need An Emergency Medication

While most of the time you will have your emergency medication filled at the Midwest Benefit Pharmacy, there are times when you need to have an emergency medication filled right away. The Plan will reimburse you for 80% of the cost of your emergency

An Emergency Medication is a medication that is medically necessary and is not known to be needed in advance, such as an antibiotic.

medication if you use a network pharmacy and your prescription is for a maximum of 15 days.

You must show your Midwest Operating Engineers Fringe Benefit Fund identification card if you fill your prescription at a retail network pharmacy rather than at the Midwest Benefit Pharmacy, you pay a copayment of 20% of the contracted cost at the time it is filled at the network pharmacy. You will not be reimbursed for the 20%. A maintenance prescription can only be filled once on an emergency basis.

If you have submitted a claim for your prescription to any other insurance plan, no benefits will be paid from this plan.

Prescriptions Provided by Convalescent and Nursing Homes

Prescriptions provided by convalescent and nursing homes will be reimbursed at 50% of the actual expense. You must submit a claim. If you have submitted a claim for your prescription to any other insurance plan, no benefits will be paid from this plan.

Medicare Part D Prescription Drug Coverage

If you or your spouse is eligible for Medicare and you sign up for coverage under Part D, the individual that elected Part D coverage will no longer be eligible for prescription drug coverage at the Midwest Benefit Pharmacy.

General Information About the Program and the Midwest Benefit Pharmacy

Please note the following information regarding your prescription drug benefits. If you have questions, please call the Pharmacy at (708) 579-6610.

If Your Prescription Expires

Most prescriptions expire 12 months (one year) after the date they are first written by a physician. Prescriptions for certain Schedule II Medications expire faster, see the section on **Prescription for Schedule II Medications** following. These expiration periods apply to any refills indicated on the prescription as well. If your prescription expires, you will need to submit a new prescription to the Pharmacy before it can be filled.

Phone-In Prescriptions

The Midwest Benefits Pharmacy will accept phoned-in or faxed-in prescriptions from your doctor. If you have a form of payment on file with the Pharmacy, your order will be mailed to your home address **unless** you contact the Pharmacy ahead of time to arrange pick up at the Pharmacy.

Your prescription will be filled and mailed immediately without any further instructions if have designated on file a method for making your copayment. Your copayment must be made by one of the following payment methods.

1. Direct payment from your MOE Credit Union account, or
2. Charged to your credit card (VISA or MasterCard only)

Remember, if you have not provided the Fund Office with your consent to direct pay from your MOE Credit Union account or your credit card, your prescription may be delayed in processing.

Prescription for Schedule II Medications

State law requires that you follow certain procedures when filling a prescription for a Schedule II medication. If your physician prescribes a Schedule II medication, **you must submit your written prescription to the Pharmacy within 7 days (including the date the prescription is written).**

To ensure the Pharmacy receives the prescription within 7 days, submit the prescription in person or use priority mail or overnight delivery. The Pharmacy will fill your prescription and send it to you via UPS delivery (at no additional charge to you). If the prescription is not received in time, your physician will need to write a new prescription.

Ways to Pay for Your Copayment

How you may pay for any copayment depends on how the prescription is delivered as the following chart indicates:

If you...	You may pay with...
Pick up your prescription in person	Cash, personal check, or credit card (MasterCard or VISA)
Mail in your prescription	Credit card (Master Card or Visa) or credit union transfer
Call in your prescription to be mailed	Credit card or credit union transfer

Prescription Payments

- Did you know that the Local #150 Credit Union can transfer funds to the Pharmacy from your account? This process can help expedite your prescription drug orders. For more information about this payment option, please contact the Credit Union at (708) 482-

9606.

Helpful Hints

Here are some suggestions that you might find useful when filling your prescriptions through the Midwest Benefit Pharmacy Program.

Every Time You Place An Order

Whenever you place a prescription drug order with the Pharmacy, always include the member's social security number or unique member identification number.

New Prescriptions

- If your doctor is writing a new prescription for a **long-term medication**, ask him or her to write the prescription for a 90-day supply. This allows the Pharmacy to dispense up to three orders at one time.
- Make sure your doctor writes the patient's **full name** (including Jr., Sr., etc.) and writes specific directions for taking the medication. If the doctor simply writes, "as directed," the Pharmacy will have to call for more information and this could delay the processing of your prescription.
- If you are mailing in a new written prescription, it's not necessary for your doctor to phone in the prescription as well.
- A prescription can only be transferred from another pharmacy to the Midwest Benefit Pharmacy after it has been filled at least **once** at the other pharmacy.
- The Midwest Benefit Pharmacy staff can call your doctor for you to request information about a new prescription. However, you'll need to contact your doctor's office beforehand so that they are aware of which prescriptions you need when the Pharmacy calls.
- If you are unsure whether or not a generic substitution is available for a new prescription, call the Pharmacy to find out. If you send in your prescription without a method to make

your copayment, the Pharmacy won't be able to fill your prescription until it receives the required copayment.

Special Address Request

If you're taking a trip or live at different locations during the year, you can request that your prescription be sent to a special address. All you have to do is include a note with each prescription order that specifies where the prescription should be sent.

Covered Expenses

To be considered a covered expense under the Program, a prescription must be issued by a legally qualified physician for a covered illness or accident and must be a legend drug.

Legend drugs are those that must be obtained by doctor prescription, as opposed to those prescribed by a doctor but available over the counter.

As new drugs become available, they are normally covered. However, the Board of Trustees reserves the right to review industry practices and consult with medical advisors before determining how the new drugs will be covered through the plan. Experimental or investigational drugs are not covered through the plan.

Expenses Not Covered

Expenses for the following drugs are not covered:

- Research or experimental drugs.
- Over-the-counter items.
- Drugs taken or administered in a hospital or doctor's office.
- Contraceptive devices, including I.U.D.'s and diaphragms.
- Drugs that promote fertility, except those noted below.

- Drugs that promote hair growth, including Propecia.
- Viagra and similar drugs.
- Non-drug items, regardless of intended use.
- Non-emergency medical prescriptions filled at any retail pharmacy, emergency medical prescriptions filled at an Out-of-Network pharmacy, more than a 15-day supply of an emergency medical prescription filled at an In-Network pharmacy, or more than a 90-day supply of a drug filled at the Midwest Benefits Pharmacy.
- Any drug charges that exceed the Maximum Prescription Drug Benefit, except for drugs used in outpatient chemotherapy treatment.

Expenses Covered With Limitations

The following drugs are covered with the limitations listed:

- Retin A - Must have diagnosis for a medical condition/not cosmetic.
- Renova - Must have a diagnosis of acne.
- Progesterone - must have diagnosis for a medical condition other than infertility.
- Crinone Gel - must have diagnosis for a medical condition other than infertility.
- Muse - maximum box of 6 dispensed.
- Caverject - maximum box of 6 dispensed.
- Toradol - limit of 6-day supply.
- Lancets and test strips - boxes of 100 dispensed.
- Epipen and Epipen, Jr. - maximum of 2 dispensed.

DENTAL BENEFITS

Dental care benefits are available to you and your family through the Midwest Operating Engineers Dental Plan.

How Benefits Are Paid

There is no deductible to satisfy before benefits begin. Benefits payable (other than for preventive services) are based on a **Maximum Allowable Fee Table** (see page you are receiving a brand name medication requiring a co-paymen) on the type of service received:

Preventive Services (exams, cleanings, and bitewing X-rays)	100% (not subject to Maximum Allowable Fee)
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Basic and Restorative Services (fillings, crowns, root canal therapy, oral surgery, dentures, bridgework, and other covered dental services)	70% of Maximum Allowable Fee
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Orthodontics (children under age 19)	50% of Maximum Allowable Fee up to a lifetime maximum benefit amount of \$1,500 per covered child.
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The Midwest Operating Engineers Dental Plan pays up to **\$1,000** per person in benefits each calendar year for covered dental services. 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.

Maximum Allowable Fee Table

The Midwest Operating Engineers Dental Plan provides benefits for non-preventive services based on a **Maximum Allowable Charge Table**. If you go to a non-PPO dentist and he or she charges more than the Maximum Allowable Charge for a covered service, the plan will pay benefits based on the Maximum Allowable Charge. If the dentist charges *less* than the Maximum Allowable Charge, the plan will apply the appropriate copayment level to your entire dentist's fee (i.e. 100%, 70% or 50%) to determine its payment.

The Dental PPO Network

You can reduce your out-of-pocket costs when you receive services from a dentist who belongs to *The Guardian Dental PPO Network*. To belong to the Dental PPO Network, a dentist must meet strict quality assessment criteria required by Guardian. In return for our membership's business, the dentists in this network have agreed to accept the Fund's Maximum Allowable Charges 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 Charges.

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 Charge for any covered service in addition to any copayment due. Preventive services are not subject to Maximum Allowable Fees.

If you would like assistance in selecting a Dental PPO Network dentist, call Guardian's Member Services Department at (888) 600-2580 and identify yourself as a member of the Midwest Operating Engineers Health and Welfare Fund. Dental PPO Network directories are also available at the Fund Office.

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

Orthodontia Treatment

Benefits for orthodontia treatment are available to dependent children under age 19. Orthodontic treatment basically consists of three phases: diagnosis, banding and treatment. If your child is diagnosed by an orthodontist for braces, the orthodontist should submit a treatment plan to the Fund Office. The treatment plan should contain the following information:

- Estimated number of months of treatment
- Total fee
- Cost for initial placement of appliance (banding)
- 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 the Fund Office on a monthly basis. The Plan pays 50% of the cost for the placement of the appliance and then 50% of the monthly bills until the \$1,500 lifetime maximum is reached.

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). Plan benefits will be prorated based upon the original payment agreement with the orthodontist.

Limitations

Benefits for covered expenses are limited as follows:

- \$1,000 annually for each covered person.
- Oral examinations, prophylaxis (routine or periodontal maintenance) and fluoride applications are limited to twice per calendar year.
- Full mouth or panoramic X-rays are limited to one every 24 months unless medically necessary.
- Bitewing X-rays are limited to twice every calendar year.
- Orthodontic services are covered for dependent children up to the age of 19. The benefit is subject to a lifetime maximum payment of \$1,500.
- Benefits for fillings are limited to silver amalgam, silicate, and plastic.
- 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 included as an eligible benefit under any group medical or dental benefit plan which

covers the eligible dependent as the insured (Coordination of Benefits). See page 70.

Exclusions

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

- Charges for prescription drugs. Please note that prescription drug coverage for dental treatment may be available through the Prescription Drug Program.
- Charges for the replacement of a lost or stolen dental appliance.
- Replacement of a bridge, crown or denture within five years of the date it was originally installed. However, replacement is covered if:
 - the full denture is made necessary by extraction of natural teeth; or
 - the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.
- 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 Comprehensive Medical Benefit.
- Treatment rendered by someone other than a licensed Dentist except for scaling and cleaning of teeth and application of fluoride and/or sealants by a licensed dental hygienist, when such services are rendered under the supervision and guidance of a dentist.
- Charges for any procedure not completed, or any prosthetic appliance unless the appliance is actually inserted or delivered.

- Completion of claim forms or charges for missed or broken appointments.
- Charges for home medicaments, prescribed drugs, pre-medication, analgesia, or local anesthesia.
- Temporary 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 a covered expense. Excluded services shall include, but are not limited to:
 - Increasing vertical dimension
 - Periodontal splinting
 - Realignment of teeth
 - Orthognathic recordings
 - Replacing or stabilizing tooth structure loss by attrition
- Any treatment or procedure occurring after a person's coverage terminates.
- Subgingival curettage and/or root planing (ADA codes 4220, 4331, and 4345) 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 treatments.

If You Have Questions

If you have any questions about your Dental Benefits, call the Fund's Claim Department at (800) 323-3060 or (708) 579-6600.

FAMILY SUPPLEMENTAL BENEFIT

If you and your eligible dependents incur medically necessary unreimbursed expenses for Covered Expenses under the Plan, those expenses will be reimbursed up to the \$1,500 maximum benefit per family per Calendar Year.

Eligible Expenses

Eligible Expenses include any non-covered, unreimbursed medical, dental and vision expenses provided the expense would be deductible for tax purposes. These include:

- Medical supplies,
- Speech therapy, and
- Prescription drugs not covered under the Plan.

Requests for reimbursement must be received by the Fund Office no later than one year from the date the expense was incurred.

Exclusions

No benefits are payable for these expenses:

- Expenses that apply toward deductibles;
- Co-insurance amounts other than for benefits paid at 50%;
- Amounts that are used to satisfy out-of-pocket maximums;
- Expenses that are covered by the plan; and
- Expenses that are not deductible for income tax purposes.
- Over the counter medication that does not require a prescription

Examples of Eligible and Excluded Expenses

Eligible Expenses	Excluded Expenses
<ul style="list-style-type: none">➤ Dental expenses over \$1,000 for an individual➤ Prescription eyeglasses or contacts➤ Hearing tests and aids➤ Routine physicals for children over the age of 2➤ Contraceptive devices➤ Non-covered prescription drugs➤ Orthodontic expenses over \$1,500 per dependent child and those expenses paid at 50%➤ Items that are not covered at 100% and are not counted toward the Plan's out-of-pocket maximums such as medical supplies, speech therapy and TMJ treatment	<ul style="list-style-type: none">➤ Any weight loss program➤ Any smoking cessation programs➤ Any exercise program, health club dues or membership fees➤ Hot tub or jacuzzi➤ Cosmetic treatments such as teeth bleaching kits or treatments, cosmetic surgery, facials, etc.➤ Pharmacy co-pays➤ Group insurance premiums from your spouse's employer

NON-OCCUPATIONAL WEEKLY DISABILITY BENEFIT

As an active eligible employee, you may receive a **weekly disability benefit** if for more than eight consecutive days because of an injury or illness you are unable to work, and you are under the regular care of a doctor (M.D. or D.O.).

- The maximum amount you may receive per week is \$250 less any amounts you receive from:
 - a wage continuation program through your employer;
 - a group insurance plan, government plan, or another employee welfare plan;
 - the Midwest Operating Engineers Pension Fund Total and Permanent Disability Benefit provisions;
 - any similar pension plan that requires employer contributions to the Midwest Operating Engineer Health and Welfare Fund; and
 - Workers' Compensation or Occupational Disease laws.

- Partial weeks of disability are paid at a daily rate of \$35.72 (\$250 divided by 7 days).

- You may receive this benefit for up to 52 weeks for each disability period.

- For the first 17 weeks of disability you receive credit for continued eligibility at the rate of 40 hours per week. If your injury or illness continues longer than 17 weeks and you continue to qualify for a Weekly Disability Benefit, you can continue your coverage for a maximum of four consecutive contribution quarters through self-payments.

- You must provide the Fund Office with medical certification of your illness or injury period from a legally qualified physician on a continuing basis. You may be required to be examined by a doctor, M.D. or D.O, specified by the Fund's Administrative Manager at any time during the period you are receiving this benefit.
- Successive periods of disability separated by less than two weeks of active, full- time employment are considered as one period.
- By law this benefit is subject to federal income taxes and the Fund will withhold applicable Social Security (FICA) taxes.

Exclusions

No benefits shall be payable for any:

- disability resulting from Illness or Injury for which an Eligible Employee is not under the care of a doctor (M.D. or D.O.)
- disability for which the Employee has a right to payment under any Workers' Compensation law or occupation disease law;
- disability that is work related; or
- disability resulting from a loss, problem, complaint, pain or ailment which did not arise from an objectively determined and documented medical impairment.

DEATH BENEFITS AND ACCIDENTAL DISMEMBERMENT BENEFITS

Death Benefits

This plan provides a **death benefit** for active employees and their eligible dependents, as follows:

- death of an active employee - \$30,000
- death of an active employee's spouse - \$2,000
- death of an active employee's eligible dependent child - \$2,000

You may designate a beneficiary to receive your death benefit. If you don't, payment will be made in the following order:

- to your legal spouse; or, if not living,
- equally to your children; or, if not living,
- to your parents in equal shares; or, if not living,
- to your estate.

If your spouse dies, payment will be paid to you if living; otherwise, payment will be made to his or her estate.

If your dependent child dies, payment will be made as follows:

- to you; or, if not living,
- to your spouse; or, if not living,
- to any remaining brothers or sisters in equal shares; or, if not living,
- to the child's estate.

You should be aware that benefits payable under this provision may be taxable.

Accidental Dismemberment Benefits

An **accidental dismemberment benefit** is available to you while an active employee if you suffer a bodily injury either on or off the job. If the injury causes one of the following losses to occur after an accident, you will receive a benefit. Your benefit is determined according to the following schedule.

This benefit is payable for the loss of:

- each hand - \$5,000
- each foot - \$5,000
- each eye - \$5,000
- each finger, including thumb - \$1,000

The maximum benefit payable is \$10,000 for any combination of losses.

GENERAL EXCLUSIONS

The following charges and services are not covered under this plan:

- 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);
- services or supplies that are not considered medically necessary;
- services or supplies that are not prescribed by a licensed physician;
- 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;
- any treatment or service not prescribed by an eligible provider (licensed to prescribe the treatment or service) as defined on page 86;
- an illness or injury resulting from war or any act of war, or from the commission of a felony;
- Expenses for medical surgical or prescription drug treatment related to transsexual procedures, or the preparation of such treatment, or any complications resulting from such procedures.
- illness or injury for anyone who is serving in the Armed Forces of the United States or any other government;
- custodial or maintenance care;

- cosmetic surgery and all related expenses;
- foot orthotics, pelvic stabilizers, and all casting costs except as otherwise covered under the Protheses and Support Devices Benefit (see page 40);
- braces, trusses, and foot orthotics that can be purchased over the counter;
- orthodontic services and supplies except as specifically provided for under the plan;
- any services or supplies for which:
 - no charge is made,
 - the individual is not legally required to pay,
 - the Fund is not legally required to pay;
- any routine physical, or service or supply utilized where no illness or accident is present or required for employment, unless otherwise provided for under the Physical Examination Benefit or the Well Baby Care Benefit;
- eye exams, except for treatment of accidental injuries;
- procedures, such as RK, for surgical correction of myopia or other refractive errors;
- smoking cessation programs;
- supplies such as bandages, gauze, tape, syringes and needles (unless provided and used while in the hospital);
- speech or occupational therapy except as specifically provided under the plan;
- telephone, television, cot rental, guest meals, travel, copying of medical records or fees to

complete a claim form;

- vocational therapy or any other therapy, except as specifically provided in the plan;
- charges by an eligible provider who is the parent, spouse, child, or sibling of, or resides with the covered person;
- hormone therapy, artificial insemination, in vitro fertilization or other treatments for infertility in a male or female;
- preventative vaccinations, food supplements and immunizations, unless otherwise provided for under the Physical Examination Benefit or Well Baby Care Benefit;
- experimental or investigational procedures, or
- expenses incurred outside of the U.S.

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

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.

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 their benefits so that the total benefits available to you 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 eligible expenses. An eligible 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.

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 following rules apply:

- the plan that covers a patient as an employee is primary over a plan that covers the patient as a dependent;
- the plan that covers a patient as an employee is primary over a plan that covers the patient as a retiree;
- when both parents, member and spouse, have medical coverage for their children, the 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 parent's plan does not have this birth date priority, then the other plan's rules will

govern. If none of these rules apply, the plan that has covered the patient the longest is primary.

In the event a father and mother are legally separated or divorced, 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 shall 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 without custody.

In the case of a government employee who is continuing coverage under this plan through coverage payments, the governmental plan he or she is also covered under will always be considered the primary plan. Benefits through this plan are for secondary coverage only.

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.

If the patient's primary plan is a Health Maintenance Organization (HMO) or Dental Maintenance Organization (DMO), he or she is required to utilize the approved HMO or DMO providers and follow all other applicable HMO rules.

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 such reduction is not considered in determining the benefits payable under this plan.

Coordination with Medicare

At age 65 you normally become eligible for Medicare. However, Medicare eligibility also extends to disabled individuals and those with certain conditions. For example, Medicare covers certain expenses for kidney dialysis.

If you are covered by both Medicare and this plan, then:

- If you are an active member, this plan is primary.
- If you are a non-active member, Medicare is primary.

You are an active member if you are actively employed by an Employer which pays all or part of the required contributions for eligibility

When Medicare is primary, you must submit fully itemized bills and the matching Medicare Explanation of Benefits. And 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.

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 elect Medicare Part C coverage, the coordination of benefits rules will be applied if you are active. However, if you elect Medicare Part C as a retiree, coverage under this Plan ends.**

THIRD PARTY RECOVERY REIMBURSEMENT (SUBROGATION)

If you or an eligible dependent becomes ill or is injured and a third party is responsible, you may be able to recover expenses from a responsible third party, Workers' Compensation, the insurer, or a group plan. If that happens, the Trustees have the right to require you to repay any applicable benefits you or your dependent received from this medical plan. The Trustees may, at their own discretion, pursue a claim against any third party, including the filing of a claim in court. The Trustees have the right to require you to sign a Subrogation Acknowledgement to attest to your understanding of the subrogation provisions.

If you accept a settlement or receive an award, future medical expenses for any injury or illness caused by the responsible third party are not eligible expenses under this plan for the two-year period following the settlement for an injury-related claim. It is your duty to notify the Fund Office of any potential third party liability and any settlement of a claim.

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.

HOW TO FILE A CLAIM

For your claim forms to be processed quickly, they need to be completed correctly and include all necessary information and documentation. If you submit a claim form that is missing necessary information, it will be returned to you.

Claims for Blue Cross/Blue Shield participating providers will be submitted by your provider to Blue Cross/Blue Shield. You must show your ID card at the time of service. Claims for all other benefits should be sent to the Fund Office at the address on your claim form. In the event an excess or erroneous benefit payment is made, the Fund Office will ask for a refund.

Generally, providers who participate in networks will file claims on your behalf. However, it's your responsibility to ensure claims are filed.

Filing a Medical Benefits Claim

To help ensure that your medical claims are paid as quickly as possible, show your plan identification (ID) card to your health care provider whenever you receive covered services.

Claims for in-network (PPO provider) medical services may be submitted *for* you by your PPO provider. In the event that you need to file a medical claim, follow these instructions:

Each time you are filing a claim, a fully completed claim form for you and your eligible dependents should be sent to the Fund Office. Each time you submit bills, the bills must contain the following:

- your full name;
- your Social Security number or Unique Medical Identification number;
- your current home address;
- the illness or injury being treated and the date of care;
- the patient's name; and
- itemized charges.

Normally, the provider will require you to sign a form, assigning benefits. In that case the benefits are paid directly to the provider. If you paid for the service yourself, you should attach proof of payment (for example, a cancelled check or receipt) if you want payment made directly to you.

Claims should be submitted **as soon as possible**. The Trustees have a right to deny claims submitted after 1 year from the end of the date in which the expense is incurred, unless it was not possible to submit them by that time.

Filing a Dental Benefits Claim

To file a claim for covered dental services, submit a completed dental claim form to:

Midwest Operating Engineers
6150 Joliet Road
Countryside, IL 60525

To request a dental claim form, please contact the Fund Office at (708) 579-6600 or your district office.

Make sure that you sign the claim form before it is submitted to the Fund Office. Benefits will be paid directly to your dentist unless the claim form/bill is marked "paid in full."

Filing a Family Supplemental Benefit Claim

The Family Supplemental Benefit can reimburse a variety of expenses. It is up to you as the member to determine how you wish to use it.

To file a Family Supplemental Benefit claim, you must submit a Family Supplemental Benefit Claim Form along with your itemized bill and receipt of payment or your Explanation of Benefits (EOB) from the Fund Office relating to the claim. You must file your Family Supplemental Benefit claim within 1 year from the date in which the expense is incurred.

Remember, if you do not use a Family Supplemental Benefits Claim Form, the Fund Office may not recognize your claim as being submitted for the Family Supplemental Benefit. This may result in your claim payment being delayed or denied.

Filing a Weekly Disability Benefits Claim

Contact the Fund Office for a Disability Claim Form. Complete your personal information and have your physician complete the remaining information. You must submit this claim form to the Fund Office within 90 days after the date your disability begins.

Filing a Death or Accidental Dismemberment Benefits Claim

To claim either the Death or Accidental Dismemberment benefits, proof of death or dismemberment must be sent to the Fund Office. In the event of death, application for benefits should be made within 30 days of the date of death. Please call the Fund Office for the proper forms.

Claim Review

If you are denied benefits in whole or in part, the Fund Office will send you a written notice explaining why your claim was denied and the appeal procedure for having your claim reviewed.

If you disagree with the denial, you have the right to have your claim reviewed. After you receive written notice that your claim or any part of your claim is denied, you have 180 days to request a review of your claim by the Review Panel. You may also request to appear at the review hearing.

The Review Panel is made up of one Union and one Management Trustee. You also have the right to examine all documents, information and other materials related to the plan and to your claim for benefits. If you would like a review, send a written request to the Administrative Manager at the Fund Office.

In most cases, the Review Panel will make its decision within 60 days after receiving your request for a review. If circumstances require more time, however, the Panel has a maximum of 120 days to review your claim. You will receive written notice from the Panel if additional days are required, stating the reason why.

ADMINISTRATIVE INFORMATION

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

Plan Sponsor

Board of Trustees
Midwest Operating Engineers Health
and Welfare Fund
6150 Joliet Road
Countryside, Illinois 60525
(708) 482-7300

Plan Administration

The Board of Trustees

Administrative Manager

Mr. David S. Bodley

Employer Identification Number

EIN - 36-6109395

Plan Number

501

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. 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 participants 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.

Collective Bargaining Agreements

This plan is maintained pursuant to Collective Bargaining Agreements between employer Associations and Local 150. The Fund Office will provide an employee, upon written request, with information as to whether a particular employer is contributing to the Fund on behalf of employees working under the Collective Bargaining Agreements. The Fund Office will also provide you, at cost and upon written request, copies of the Collective Bargaining Agreements.

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 employees and their eligible dependents and defraying reasonable administrative expenses.

Trustees

The Board of Trustees is responsible for the operation of the plan. The Board of Trustees is made up of an equal number of employee representatives selected by Local 150 and employer representatives selected by employer Associations whose members have entered into Collective Bargaining Agreements with Local 150. They may be contacted at:

The Board of Trustees
Midwest Operating Engineers
Health and Welfare Fund
6150 Joliet Road
Countryside, Illinois 60525
(708) 482-7300

UNION TRUSTEES

William E. Dugan, President

Steven M. Cisco

Marshall Douglas

Dave Fagan

Jim Sweeney

EMPLOYER TRUSTEES

John E. Kenny, Jr., Secretary-Treasurer

Michael Piraino

Mamon Powers, Jr.

David Snelten

Glen Weeks

ADMINISTRATIVE MANAGER

David S. Bodley

Agent for Service of Legal Process

Bernard M. Baum, Esq.

Baum, Sigman, Auerbach, Pierson, Neuman & Katsaros, Ltd.

200 West Adams Street, Suite 2200

Chicago, Illinois 60606-5231

or

Michael W. Duffee, Esq.

Matkov, Salzman, Madoff and Gunn

55 East Monroe Street, Suite 2900

Chicago, Illinois 60603-5209

Legal process also may be served on the Plan Trustees.

Plan Year

The Plan Year begins on January 1 and ends the following December 31.

Right to Modify the Plan

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 method and amount of self-payments and the eligibility criteria or self-payments under the plan. You will be notified of any changes, and all changes would be subject to the plan's provisions and applicable laws.

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 booklet provides accurate and essential information about the Welfare plan, it is not a complete description. If there is ever a conflict between this booklet and the plan's legal document, the plan document will control.

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 in the next section.

YOUR ERISA RIGHTS

As a participant in Health and Welfare Plan of the Midwest Operating Engineer Health and Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include 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 Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
 - You lose coverage under the Plan;
 - You become entitled to elect COBRA continuation coverage; or
 - Your COBRA continuation coverage ceases.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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 the 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 \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which 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 domestic relations order or a medical child support order, 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 Plan Administrator. 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration. For single copies of publications, contact the Pension and Welfare Benefits Administration Brochure Request Line at 1-800-998-7542 or contact the PWBA field office nearest you.

You may also find answers to your Plan questions at the website of the PWBA at <http://www.dol.gov/dol/pwba/>. A list of PWBA Field Offices is located at <http://www.dol.gov/dol/pwba/public/contacts/folist.htm#TOF>.

DEFINITIONS

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

Eligible Provider. Eligible provider means 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:

Physicians	Practitioners	Providers
Doctor of Medicine (M.D.)	Clinical Psychologist	Home Health Care Agency
Doctor of Chiropractic (D.C.)	Clinical Social Worker	Licensed Ambulatory Care Facility
Doctor of Dental Surgery (D.D.S.)	Clinical Professional Counselor	Licensed Ambulance Service
Doctor of Osteopathy (D.O.)	Certified Mental Health Counselor	Hospital
Doctor of Podiatry (D.P.M.)	Certified Registered Nurse Anesthetist (CRNA)	Laboratory
Doctor of Chiropody (D.P.M., D.S.C.)	Licensed Speech Therapist	Skilled Nursing Facility
Doctor of Medical Dentistry (D.M.D.)	Licensed Occupational Therapist	Hospice
	Licensed Physical Therapist	
	Optometrist - accidental injury to eye only	
	Orthoptic Technician - orthoptic benefit only	

Investigative/Experimental Treatment. Investigative Treatment or Experimental Treatment is defined as a trial procedure or protocol done on a minimal number of patients to establish data for a rate of cure or improvement in the quality of life.

The randomized trial establishes if benefits result that are greater than the conventional therapy approved by the American Medical Association or similar governing body. No reimbursement is provided for care deemed to be investigative or experimental in nature. A more complete definition is provided in the plan document.

Medically Necessary Expenses. Medically Necessary Expenses include, but are not limited to, services and supplies which:

- 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 sickness or injury,
- are consistent with the signs, symptoms or diagnosis and treatment of a sickness or injury,
- are not primarily for the convenience of the eligible person or his doctor,
- are the most appropriate supply or level of service which can be safely provided,
- are necessary and appropriate treatment of the sickness or injury,
- are not experimental or investigative in nature,
- are not cosmetic in nature; that is, the treatment restores or repairs function.

Network Negotiated Fees. The fees that have been negotiated by the networks for services provided by network providers for each service. All providers in the network have agreed to

charge only the fees negotiated for each service.

Reasonable and Customary Charges. Reasonable and Customary Charges are the actual charges for services or supplies rendered to the extent the fee is reasonable and does not exceed the customary fee for comparable services or supplies charged within the community where the services are provided. Charges for services must not be higher than those made by persons with similar professional standing, training, and experience.