Operating Engineers Local #49 Health and Welfare Plan

	Active Hourly Employees
Calendar Year Deductible*	$500 per covered person $1,000 per family
Out of Pocket Maximum** (After Deductible Has Been Satisfied)	$2,500 per covered person $6,000 per family
Inpatient Services provided in (or billed by) Hospitals	80% Plan copayment at Participating Providers *No coverage at Non-Participating Providers****
Emergency Services	80% Plan copayment
Ambulance	80% Plan copayment
Home Health Care	80% Plan copayment 90 Visits per Calendar Year
Skilled Nursing Care	80% Plan copayment 2 days for each day of hospital confinement, up to 60 days
Hospice Care	100% Plan payment 180-day maximum *No coverage at Non-Participating Providers****
Outpatient Services provided in (or billed by) Hospitals, Clinics, or Urgent Care Centers	80% Plan copayment at Participating Providers 70% Plan copayment at Non-Participating Providers
Office Visits and Lab Charges (Includes Telehealth Online or Phone Consultations)	$25 copayment at Participating Providers 70% Plan copayment at Non-Participating Providers
Minute Clinic (or any other freestanding clinic found in a retail setting)	100% Plan payment $25 Maximum Payment per Visit
Doctor On Demand	100% Plan payment
Chiropractic and Acupuncture Treatment	100% Plan payment up to 19 visits combined per year
Physical Exam & Routine Immunizations	100% Plan payment at Participating Providers and Participating Pharmacies 80% Plan copayment at Non-Participating Providers
Health Dynamics Physical	100% Plan payment for employee and/or spouse
Health Dynamics Physical Incentive Benefits	Comprehensive Examination Waiver of Calendar Year Deductible in the calendar year following the 12 month period (December – November) in which the physical is completed Choice of $20/mo. Gym/Health Club Reimbursement (up to 12 mo.) OR $240 Copay and Coinsurance Reimbursement for 12 months Primary MD Examination Choice of $20/mo. Gym/Health Club Reimbursement (up to 12 mo.) OR $240 Copay and Coinsurance Reimbursement for 12 months
Colonoscopy	Routine - 100% Plan payment at Participating Providers 80% Plan copayment at Non-Participating Providers
Imaging Benefit	Most medical imaging exams such as MRI, CT and X-Ray performed at a RAYUS facility allows 100% coverage
Prescription Drug Benefits	20% copayment $2,500 annual out-of-pocket limit per covered person $5,900 annual out-of-pocket limit per family Additional $1,800 annual out-of-pocket limit per family for Specialty Drugs
Birth Control Pills	100% Plan payment for in-network generic 80% Plan copayment for brand
Erectile Dysfunction	50% Plan copayment (up to 6 pills per month)
Smoking Cessation Products	100% Plan payment for over the counter products when enrolled in the Plan's smoking cessation program 80% Plan copayment for prescription products when enrolled in the Plan's smoking cessation program
Vision Benefit (Exams, Frames, Lenses, Contact Lenses)	$500 Allowance per 2 Calendar Years (allowance replenished on the 1st day of every even year)
LASIK Eye Surgery	100% Plan payment up to $500 per eye once per lifetime
Hearing Aids	$2,000 once every 5 calendar years for new devices or repairs, no batteries
Cochlear Implants	80% Plan copayment
Accident & Sickness Weekly Benefit	$300 per week up to 26 weeks for non-occupational injury or sickness
Death Benefit	$8,000
Accidental Death & Dismemberment Benefit	$8,000 Principal Sum
Foot Orthotics	100% Plan payment up to $400 every 12 months

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	Active Hourly Employees
Dental Benefits	100% Plan payment for preventive and diagnostic services Routine dental exams and cleanings are covered 2 times per calendar year, instead of once every 6 months 80% Plan copayment for all other services $2,000 Maximum Payment per Calendar Year (does not apply to participants under the age of 19)
Orthodontia (Medically Necessary for oral surgery, cleft palate repair or accidental injury to teeth)	$2,000 Lifetime Maximum
Orthodontia (for dependent children only)	$1,000 Lifetime Maximum
TMJ	$800 Maximum Payment per Lifetime 80% Plan copayment

*** Calendar Year Deductible** - You must pay all costs up to the Deductible amount before the Plan will pay for covered services you incur. The Deductible resets at the beginning of each year.

**** Out of Pocket Maximum** - The Out of Pocket Maximum is the most you could pay during the annual coverage period for your share of the cost of covered services. The Calendar Year Deductible does not count toward your Out of Pocket Maximum.

***** The Plan continues to cover all Emergency Medical Conditions as detailed under Emergency Services.**

This benefit schedule is accurate as of the date it was printed. However, the Trustees continuously monitor and modify the benefit schedule as necessary when new programs are contracted, when plan design changes take place, as a result of technological changes, and when legislative changes are required. Refer to the Summary Plan Description (SPD), along with any Summary of Material Modifications (SMM), to assure the most up to date benefit schedule. For more information visit www.health49.org or contact Wilson-McShane Corporation at 952-854-0795, toll free 1-800-535-6373.

The Summary Plan Description (SPD) and the Trust Document establish the terms of the Plan. If there is any discrepancy between the content of this summary and the SPD, the SPD governs. In addition, this benefit schedule is intended as a reference document only, for a full description of available benefits, please consult the current SPD and SMM.