

**To: All Participants and Beneficiaries in the Health and Benefit Trust Fund of the International Union of the Operating Engineers Local Union No. 94-94A-94B, AFL-CIO**

**From: The Plan Administrator of the Health and Benefit Trust Fund of the International Union of the Operating Engineers Local Union No. 94-94A-94B, AFL-CIO**

**Re: Summary of Benefits and Coverage – Medicare Retiree Coverage for the Commercial Division**

**Date: November 29, 2017**

Enclosed you will find the Summary of Benefits and Coverage (“SBC”) for the Health and Benefit Trust Fund of the International Union of Operating Engineers Local 94-94A-94B, AFL-CIO (“Fund”) that pertains to the benefit coverage option offered to eligible retirees in the Commercial Division. Accordingly, this SBC summarizes available benefits for this Medicare retiree option; and is intended to comply with the applicable disclosure requirements under the Patient Protection Affordable Care Act (“ACA” or the “Affordable Care Act”). Please share this SBC with your family members who are eligible for this health coverage under the Fund.

*Please note that if you have coverage under a different coverage option, you will receive a separate SBC describing that coverage. As such, there are separate SBCs that describe the Fund’s benefits for the Commercial Active, Commercial Retiree PPO, School Active, Commercial Basic Retirees and School Retirees.*

The federal government developed a model SBC form primarily to help people who will shop for individual health coverage on the health care exchanges. The SBC is designed so that individuals can conduct an “apples to apples” assessment of the material benefits and costs when comparing different health plan coverage. For that reason, we were not allowed to customize much of the enclosed SBC and, therefore, some aspects of it may not be relevant to the Fund’s benefit coverage option for the Commercial Division.

#### *SBC Disclosure Requirement under ACA*

Generally speaking, the Affordable Care Act has some very strict disclosure requirements for the SBC - the maximum number of pages, the font size, the colors, etc. To best understand the benefits provided by the Fund’s benefit coverage option for the Commercial Division, we recommend that you refer to the benefit materials that you are use to seeing from the Fund - our website, [www.local94.com](http://www.local94.com), the Open Enrollment Materials, the Summary Plan Description (“SPD”) and other Fund - documents in conjunction with your review of the enclosed SBC and for comparative purposes to SBCs issued by other plans or insurers.

In accordance with the applicable disclosure requirements under ACA, the SBC includes three examples - one for having a baby, one for managing type 2 diabetes, and one for a simple fracture emergency room visit and follow up care. The examples show the health care costs for you and the Fund associated with each of these three situations. As you read these examples, it’s very important to note that these costs are national averages; they do not reflect what the actual services might cost in your area. Similarly, your course of treatment might also be very different depending on whether you receive care from an In-Network Provider or an Out-of-Network Provider (the examples only show costs for In-Network Providers), your doctor’s approach, your age, your other health issues, and many other factors. These examples are included to help someone compare how different health plans might cover the same condition - not for predicting your own actual health care expenses.

You may find that the SBC discusses the Fund’s benefits in ways that may seem unfamiliar to you. For instance, there may be terms you haven’t seen before, or terms that you have seen before but are being used differently. The SBC also refers to a “Glossary of Health Coverage and Medical Terms,” which cannot be customized for the Fund. If you read the SBC or the Glossary and find yourself confused at any time, we recommend that you refer to your SPD, the Local 94 website ([www.local94.com](http://www.local94.com)) and the other materials describing your benefits that you have received or may be eligible to receive from the Fund; or contact the Fund Office at (212) 541-9880.

*For More Information*

Please keep this SBC with your copy of the SPD for easy reference. Please note that receipt of this document does not constitute a determination of your eligibility for benefits under the Fund. If you have any questions about Fund-provided coverage, please call the Fund Office at (212) 541-9880. If you have general questions about the SBC or the Glossary, you may want to contact the Employee Benefits Security Administration of the U.S. Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 Ext. 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**IMPORTANT NOTICE REGARDING THE FUND'S GRANDFATHERED PLAN STATUS**

The Board of Trustees believes that the Fund is a "grandfathered plan" as such term is defined under the Affordable Care Act. As permitted by this law, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the Affordable Care Act was enacted. Being a grandfathered health plan means that the medical coverage that you have elected under the plan may not include certain consumer protections of the Affordable Care Act that apply to other group health plans, for example, the requirement for the provision of preventive health services without any cost sharing (i.e., copayments, coinsurance, deductibles). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and extension of coverage to dependents until age 26. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Administrator during normal business hours at: 331-337 West 44th Street, New York, New York, 10036, telephone number: (212) 541-9880. You may also contact the Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered plans.

*This notice and the enclosed SBC contain highlights of certain features of the Fund's benefit coverage option for the Commercial Division. Full details of these benefits are contained in the Fund's SPD and other official plan documents (collectively "Official Plan Documents"). If there is a discrepancy between the attached SBC (or this letter) and the Official Plan Documents, the Official Plan Documents will govern in all cases. The Trustees have the sole an absolute discretion and reserve the right to amend, modify, or terminate the Fund at any time.*

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Health & Benefit Trust Fund of the IUOE Local 94-94A-94B Fund

Commercial Division: Medicare Retirees

Coverage Period: 01/01/2018 – 12/31/2018

Coverage for: Individual + Family | Plan Type: Medicare Supplement



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the completed terms of coverage, you can view this at [www.Local94.com](http://www.Local94.com) or by calling 1-212-541-9880. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-212-541-9880 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not Applicable.	See the Common Medical Events below for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	Not Applicable.	See the Common Medical Events below for your costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not Applicable.	See the Common Medical Events below for your costs for services this <u>plan</u> covers.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable.	See the Common Medical Events below for your costs for services this <u>plan</u> covers.
Will you pay less if you use a <u>network provider</u> ?	Yes. For a list of all <u>network providers</u> , see <a href="http://www.Local94.com">www.Local94.com</a> or call 1-212-541-9880.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ).
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Not Applicable.	See the Common Medical Events below for your costs for services this <u>plan</u> covers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		<u>In-Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge	Amounts over the Medicare fee schedule.	The <u>Plan</u> pays secondary to Medicare. The <u>Plan</u> only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The <u>Plan</u> reimburses amounts of Medicare cost-sharing ( <u>deductibles</u> , <u>coinsurance</u> ). No coverage for providers who have opted out of Medicare and entered into private contracts.
	<u>Specialist</u> visit	No charge	Amounts over the Medicare fee schedule.	
	Preventive care/screening/ Immunization (You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive)	No charge	Amounts over the Medicare fee schedule.	
If you have a test	<u>Diagnostic test (x-ray, blood work)</u>	No charge	Amounts over the Medicare fee schedule.	The <u>Plan</u> pays secondary to Medicare. The <u>Plan</u> only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The <u>Plan</u> reimburses amounts of Medicare cost-sharing ( <u>deductibles</u> , <u>coinsurance</u> ). No coverage for providers who have opted out of Medicare and entered into private contracts
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	No charge	Amounts over the Medicare fee schedule.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		<u>In-Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at <a href="http://www.caremark.com">www.caremark.com</a></p>	Generic drugs	Retail: \$10 copay/prescription (30-day supply). Mail order: \$20 <u>copay</u> /prescription (90-day supply)	Not covered	<p><u>Plan</u> provides creditable coverage for Medicare-eligible individuals. <u>Plan</u> includes mandatory generic substitution policy, only two refills are available at retail and then must use mail order pharmacy or CVS pharmacy for maintenance choice at a CVS retail store</p>
	Formulary brand drugs	Retail and Mail order; 20% coinsurance to maximum \$40/prescription	Not covered	
	Non-formulary brand drugs	Retail and Mail order; 40% coinsurance to maximum \$60/prescription	Not covered	
	<u>Specialty drugs</u>	20% coinsurance to maximum \$50/prescription (per 30 day supply)	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	No charge	Amounts over the Medicare fee schedule	<p>The <u>Plan</u> pays secondary to Medicare. The <u>Plan</u> only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The <u>Plan</u> reimburses amounts of Medicare cost-sharing (<u>deductibles</u>, <u>coinsurance</u>). No coverage for providers who have opted out of Medicare and entered into private contracts</p>
	Physician/surgeon fees	No charge	Amounts over the Medicare fee schedule	
<p>If you need immediate medical attention</p>	<a href="#">Emergency room care</a>	No charge	Amounts over the Medicare fee schedule	<p>The <u>Plan</u> pays secondary to Medicare. The <u>Plan</u> only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them,</p>
	<a href="#">Emergency medical transportation</a>	No charge	Amounts over the Medicare fee	

For more information about limitations and exceptions, see plan or policy document at [www.local94.com](http://www.local94.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		<u>In-Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
	<u>Urgent care</u>	No charge	schedule Amounts over the Medicare fee schedule	up to the Medicare allowance. The <u>Plan</u> reimburses amounts of Medicare cost-sharing ( <u>deductibles</u> , <u>coinsurance</u> ). No coverage for providers who have opted out of Medicare and entered into private contracts
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge through 91st day and for 60-day Medicare lifetime reserve; thereafter, 50% <u>coinsurance</u> for days 91st to 201st day after the 60 Medicare lifetime reserve days are exhausted plus amounts over Medicare fee schedule.	Amounts over the Medicare fee schedule	The <u>Plan</u> pays secondary to Medicare. The <u>Plan</u> only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The <u>Plan</u> reimburses amounts of Medicare cost-sharing ( <u>deductibles</u> , <u>coinsurance</u> ). No coverage for providers who have opted out of Medicare and entered into private contracts
	Physician/surgeon fees	No charge	Amounts over the Medicare fee schedule	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		<u>In-Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Amounts over the Medicare fee schedule	The <u>Plan</u> pays secondary to Medicare. The <u>Plan</u> only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The <u>Plan</u> reimburses amounts of Medicare cost-sharing ( <u>deductibles</u> , <u>coinsurance</u> ). No coverage for providers who have opted out of Medicare and entered into private contracts
	Inpatient services	No charge through 91st day and for 60-day Medicare lifetime reserve; thereafter, 50% <u>coinsurance</u> for days 91st to 201st day after the 60 Medicare lifetime reserve days are exhausted plus amounts over Medicare fee schedule.	Amounts over the Medicare fee schedule	
If you are pregnant	Office visits	No charge	Amounts over the Medicare fee schedule	The <u>Plan</u> pays secondary to Medicare. The <u>Plan</u> only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The <u>Plan</u> reimburses amounts of Medicare cost-sharing ( <u>deductibles</u> , <u>coinsurance</u> ). No coverage for providers who have opted out of Medicare and entered into private contracts
	Childbirth/delivery professional services	No charge	Amounts over the Medicare fee schedule	
	Childbirth/delivery facility services	No charge through 91st day and for 60-day Medicare lifetime reserve; thereafter, 50% <u>coinsurance</u> for days 91st to 201st day after the 60 Medicare lifetime reserve days are exhausted plus amounts over Medicare fee schedule.	Amounts over the Medicare fee schedule	

For more information about limitations and exceptions, see plan or policy document at [www.local94.com](http://www.local94.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		<u>In-Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	The <u>Plan</u> pays secondary to Medicare. The <u>Plan</u> only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The <u>Plan</u> reimburses amounts of Medicare cost-sharing ( <u>deductibles</u> , <u>coinsurance</u> ). No coverage for providers who have opted out of Medicare and entered into private contracts
	Rehabilitation services	No Charge	Amounts over Medicare fee schedule	
	Habilitation services	No Charge	Amounts over Medicare fee schedule	
	<a href="#">Skilled nursing care</a>	No charge	Not covered	
	<a href="#">Durable medical equipment</a>	No Charge	Amounts over Medicare fee schedule	
	<a href="#">Hospice services</a>	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	No Charge	All balances over \$20	One exam per calendar year
	Children's glasses	No Charge	All balances over \$50	One pair of glasses per calendar year
	Children's dental check-up	No Charge for Fund panel dentists;\$15 co-pay/exam for Sele-Dent providers	All balances over \$15	One exam per calendar year. Benefit allowance schedule applies.

## Excluded services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check the “Medicare and You” handbook or the [Plan’s](#) SPD document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Clinics
- Cosmetic Surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Dental care (Adult) (Benefit allowance schedule applies)
- Hearing aids (per ear once every 3 years) (Benefit allowance schedule applies)
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration a 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), U.S. Department of Health and Human Services at 1-877-267-2323x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO, 337 West 44<sup>th</sup> Street, New York, NY 10036 via phone 212-541-9880 or U.S. Department of Labor, Employee Benefits Security Administration a 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**Does this [plan](#) provide Minimum Essential Coverage?** No.

This Plan only pays secondary to Medicare with the exception of Prescription Drugs. If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this [plan](#) meet Minimum Value Standards?** No.

This Plan only pays secondary to Medicare with the exception of Prescription Drugs. If your [plan](#) doesn’t meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

## Language Access Services:

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office for all other services 212-541-9880.

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office for all other services 212-541-9880.

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.

French Creole ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Empire Blue Cross 1-800-553-9603; CVS/Caremark 1-888-769-9054; Health & Benefit Fund Office 212-541-9880 for all other services.

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

For more information about limitations and exceptions, see plan or policy document at [www.local94.com](http://www.local94.com)



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

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

- The [plan's](#) overall [deductible](#) N/A
- [Specialist copayment](#) N/A
- Hospital (facility) [coinsurance](#) N/A
- Other [coinsurance](#) N/A

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

<b>Total Example Cost</b>	<b>\$12,800</b>
<b>In this example, Peg would pay:</b>	
<i>Cost sharing</i>	
*Deductibles	N/A
*Copayments	N/A
*Coinsurance	N/A
<i>What isn't covered</i>	
*Limits or exclusions	N/A
<b>*The total Peg would pay is</b>	<b>N/A</b>

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

- The [plan's](#) overall [deductible](#) N/A
- [Specialist copayment](#) N/A
- Hospital (facility) [coinsurance](#) N/A
- Other [coinsurance](#) N/A

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

<b>Total Example Cost</b>	<b>\$7,400</b>
<b>In this example, Joe would pay:</b>	
<i>Cost sharing</i>	
*Deductibles	N/A
*Copayments	N/A
*Coinsurance	N/A
<i>What isn't covered</i>	
*Limits or exclusions	N/A
<b>*The total Joe would pay is</b>	<b>N/A</b>

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

- The [plan's](#) overall [deductible](#) N/A
- [Specialist copayment](#) N/A
- Hospital (facility) [coinsurance](#) N/A
- Other [coinsurance](#) N/A

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

<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Mia would pay:</b>	
<i>Cost sharing</i>	
*Deductibles	N/A
*Copayments	N/A
*Coinsurance	N/A
<i>What isn't covered</i>	
*Limits or exclusions	N/A
<b>*The total Mia would pay is</b>	<b>N/A</b>

\*This Plan only pays secondary to Medicare with the exception of Prescription Drugs, Dental and Eye Care. The Plan only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts.