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 (SBC) – Active PPO Coverage for the School Division

Date: November 17, 2016

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 active participants in the School Division. Accordingly, this SBC summarizes available benefits for this benefit coverage 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, Commercial Medicare Retirees, Commercial Basic Retirees and School Retirees.

The federal government developed a model SBC form primarily to help people who will be shopping for individual health coverage when the health care exchanges opened in 2014. 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 School Division. Fortunately, you have coverage based on a Collective Bargaining Agreement between your employer(s) and the International Union of Operating Engineers, Local Union 94-94A-94B, AFL-CIO

Fortunately, you have affordable and adequate coverage under the Fund. Generally speaking, under ACA, your coverage is considered "affordable" if the premium cost for participant-only coverage is not more than 9.5% of your wages. For example, if your wages from covered employment are $40,000, your coverage would be considered affordable if your participant-only coverage does not cost you more than $3,800 a year. Since you don't pay a premium for the Fund's participant-only coverage, it is deemed affordable. In addition, the Fund's coverage meets the minimum value standard under the Affordable Care Act in that at least 60% of the benefits are covered by it. As a result, as a participant in the Fund, you don't need to shop for different or additional coverage once the healthcare exchanges open. Also, please remember that because the Fund's coverage is considered affordable and of minimum value, you are not eligible for federal premium subsidies.

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 School Division, we recommend that you refer to the benefit materials that you are use to seeing from the Fund - our website, 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 two examples - one for having a baby and one for managing type 2 diabetes. The examples show the health care costs for you and the Fund associated with each of these two 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) 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, or the U.S. Department of Health and Human Services at (877) 267-2323 Ext. 61565 or 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. 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 School 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.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or Plan Document at www.Local94.com or by calling 1-212-541-9880.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: None Out-of-Network: $200 person/$800 family. Doesn't apply to emergency room, prescription drugs, in-network benefits, exams/evaluations, preventive care and for those benefits that are administered by the Fund Office. Balance billing, excluded services, copayments and coinsurance do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this Plan begins to pay for covered services you use. Check the Plan's Summary Plan Description ("SPD") to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this Plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This Plan has no **out-of-pocket limit.**	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the Plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of all **network providers**, see www.Local94.com or call 1-212-541-9880.	If you use an in-network doctor or other health care **provider**, this Plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this Plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this Plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this Plan doesn't cover are listed on page 6. See the Plan's SPD for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visits	Deductible and 20% coinsurance + balance billing	Clinics are not covered.
	Specialist visit	$20 copay/visit	Deductible and 20% coinsurance + balance billing	
	Other practitioner office visit	$20 copay/visit	Deductible and 20% coinsurance + balance billing	Chiropractic limited to 20 visits per calendar year (In-Network and Out-of-Network combined). Clinics are not covered.
	Preventive care/screening/ immunization	Preventive care and screening (Adult): $20 copay/visit Immunizations (Adult): 20% coinsurance Well-child: No charge	Deductible and 20% coinsurance + balance billing	Annual physical available In-Network only. Subject to frequency and age limits. Clinics are not covered.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work) Genetic Testing	X-ray: 20% coinsurance Lab: No charge	Deductible and 20% coinsurance + balance billing	- Failure to precertify Genetic Testing services may result in a reduction or no benefits.
	Imaging (CT/PET scans, MRIs/MRAs Nuclear Stress Test and Echocardiogram)	20% coinsurance	Deductible and 20% coinsurance + balance billing	Failure to precertify services may result in a reduction or no benefits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail: $5 copay (30-day supply)/script Mail Order: $10 copay (90-day supply)/script	Not covered	Plan 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.
	Formulary brand drugs	Retail: $15 copay (30-day supply)/script Mail Order: $25 copay (90-day supply)/script	Not covered	
	Non-formulary brand drugs	Retail: $15 copay (30-day supply)/script Mail Order: $25 copay (90-day supply)/script	Not covered	
	Specialty drugs	20% coinsurance, max $50 per 30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fees	20% coinsurance	Deductible and 20% coinsurance + balance billing	
If you need immediate medical attention	Emergency room services	$50 copay, waived if admitted within 24 hours	$50 copay, waived if admitted within 24 hours	-- None --
	Emergency medical transportation	20% coinsurance	Deductible and 20% coinsurance + balance billing	-- None --

Common Medical Event	Services You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Urgent care	$20 copay/visit	Deductible and 20% coinsurance + balance billing	In-Network copay applies to office visit only.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fee	20% coinsurance	Deductible and 20% coinsurance + balance billing	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	Deductible and 20% coinsurance + balance billing	Clinics are not covered.
	Mental/Behavioral health inpatient services	No charge	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Substance use disorder outpatient services	No charge	Deductible and 20% coinsurance + balance billing	Clinics are not covered.
	Substance use disorder inpatient services	Detoxification: No charge Inpatient: No charge	Detoxification: Deductible and 20% coinsurance + balance billing Inpatient: Deductible and 20% coinsurance + balance billing	Detoxification: Failure to precertify may result in a reduction of benefits. Inpatient: Failure to precertify may result in a reduction or no benefits
If you are pregnant	Prenatal and postnatal care	$20 copay/initial visit then 20% coinsurance	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Delivery and all inpatient services	No charge for facility, 20% coinsurance for physician charges for delivery	Deductible and 20% coinsurance + balance billing	

Common Medical Event	Services You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	No charge	Deductible and 20% coinsurance + balance billing	Up to 200 visits per calendar year (a visit equals 4 hours of care) In-Network and Out-of-Network combined.
	Rehabilitation services	Outpatient visit: $20 copay Inpatient facility: No charge	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a reduction or no benefits. Coverage for rehabilitation, physical therapy and medicine: inpatient – up to 30 days per calendar year, outpatient 30 visits per calendar year (In-Network and Out-of-Network combined). Speech and occupational therapy covered outpatient only subject to 30 visits per calendar year limit.
	Habilitation services	Outpatient visit: $20 copay Inpatient facility: No charge	Deductible and 20% coinsurance + balance billing	
	Skilled nursing care	No charge	Not covered	Failure to precertify may result in a reduction or no benefits. Up to 60 days per calendar year.
	Durable medical equipment	20% coinsurance	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Hospice service	No charge	Deductible and 20% coinsurance + balance billing	Up to 210 days per lifetime.
If your child needs dental or eye care	Eye exam	No charge	All balances over $20	One exam per calendar year.
	Glasses	No charge	All balances after $50	One pair of glasses per calendar year.
	Dental check-up	No charge for Fund panel dentists; $15 copay/exam for Sele-Dent providers	All balances over $15	One exam per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture (except in limited circumstances up to 12 visits maximum per year)
- Bariatric surgery (except to treat morbid obesity as medically necessary)
- Clinics
- Cosmetic surgery (except reconstructive surgery related to functional defect present since birth or post-mastectomy; precertification required.)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check the Plan's SPD for other covered services and your costs for these services.)

- Chiropractic care (Maximum 20 visit per calendar year; In-Network and Out-of-Network combined; covered for member and spouse only)
- Dental care (Adult) (Benefit allowance schedule applies)
- Hearing aids (Per ear once every 3 years) (Benefit allowance schedule applies)
- Infertility treatment (Limited to member and spouse up to $12,500 combined between member and spouse lifetime maximum including drugs, subject to 20% coinsurance)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium.** Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the Fund Office at 1-212-541-9880. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO, 337 West 44th Street, New York, NY 10036 or via phone at 1-212-541-9880. You may also contact any of the Fund's claims administrators at the address and phone numbers located on the back of your ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-212-541-9880.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-212-541-9880.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-212-541-9880.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-212-541-9880.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,900
- **Patient pays** $640

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$30
Coinsurance	$460
Limits or exclusions	$150
Total	**$640**

Note: These numbers assume that the covered patient has given notice of her pregnancy to the Plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-212-541-9880.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,730
- **Patient pays** $670

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$320
Coinsurance	$270
Limits or exclusions	$80
Total	**$670**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-212-541-9880 or visit us at www.Local94.com
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-212-541-9880 to request a copy.