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 28, 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 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 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 School Division.

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 with the healthcare exchanges. 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 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) 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.

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 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 or call 1-212-541-9880 to request a copy.

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.	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Reminder: Deductible only applies to out-of-network providers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.Local94.com or call 1-212-541-9880 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Deductible and 20% coinsurance + balance billing	Clinics are not covered.
	Specialist visit	$20 copay/visit	Deductible and 20% coinsurance + balance billing	Clinics are not covered.
	Preventive care/screening/immunizations. (You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive)	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.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% coinsurance Blood work: No charge	Deductible and 20% coinsurance + balance billing	
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	20% coinsurance	Deductible and 20% coinsurance + balance billing	Failure to precertify Imaging Services may result in a reduction or no benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	Retail: $5 copay/prescription (30-day supply). Mail Order: $10 copay /prescription (90-day supply).	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/prescription (30-day supply). Mail Order: $25 copay/ prescription (90-day supply).	Not covered	
	Non-formulary brand drugs	Retail: $15 copay/prescription (30-day supply). Mail Order: $25 copay/ prescription (90-day supply).	Not covered	
	Specialty drugs	20% coinsurance, max $50/prescription (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	Failure to precertify may result in a reduction or no benefits.
If you need immediate medical attention	Emergency room care	$50 copay/visit, waived if admitted within 24 hours	$50 copay/visit, waived if admitted within 24 hours	Urgent Care: In-Network copay applies to office visit only
	Emergency medical transportation	20% coinsurance	Deductible and 20% coinsurance + balance billing	
	Urgent care	$20 copay/visit	Deductible and 20% coinsurance + balance	

For more information about limitations and exceptions, see plan or policy document at www.local94.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			billing	
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 fees	20% coinsurance	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a reduction or no benefits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Substance Abuse Care: No charge Mental Health Care: Doctor Service (outpatient/office visit) $20 copay/visit.	Deductible and 20% coinsurance + balance billing	Clinics are not covered. .
	Inpatient services	No Charge	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a reduction or no benefits.
If you are pregnant	Office visits	$20 copay/initial visit then 20% coinsurance	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Childbirth/delivery professional services	20% coinsurance	Deductible and 20% coinsurance + balance billing	
	Childbirth/delivery facility services	No charge	Deductible and 20% coinsurance + balance billing	
If you need help recovering or have	Home health care	No charge	Deductible and 20% coinsurance + balance	Up to 200 visits per calendar year (a visit equals 4 hours of care) In-Network and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs			billing	Out-of-Network combined.
	Rehabilitation services	Outpatient visit: $20 copay/visit 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). Outpatient visits for speech/language and occupational therapy: up to 30 visits per calendar year (In-Network and Out-of-Network combined).
	Habilitation services	Outpatient visit: $20 copay/visit 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 services	No charge	Deductible and 20% coinsurance + balance billing	Up to 210 days per lifetime.
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 after $50	One pair of glasses per calendar year.
	Children's 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. Benefit allowance schedule applies.

For more information about limitations and exceptions, see plan or policy document at www.local94.com

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• 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: 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, U.S. Department of Health and Human Services at 1-877-267-2323x61565 or 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 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 44th 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.

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

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

Language Access Services:
Spanish 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.

For more information about limitations and exceptions, see plan or policy document at www.local94.com

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.*

About these Coverage Examples:

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

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$610

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$870
Coinsurance	$30
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	$970

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) coinsurance	0%
Other coinsurance	20%

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

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$400