

INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 98 BENEFIT FUNDS

40 Hudson Drive, P.O. Box 1290, Southwick, MA 01077
Telephone: (413) 998-3230 • Fax: (413) 998-3249



HEALTH & WELFARE FUND
PENSION FUND
ANNUITY FUND
J L M-COOPERATIVE TRUST

KARA A. RICHOTTE
Fund Administrator



November 2022

RE: Summary of Benefits and Coverage

Dear Participant and Family,

Enclosed you will find this Fund's Summary of Benefits and Coverage (SBC). This document provides a general description of the health benefits provided by our Fund. SBCs are required by the Affordable Care Act (ACA)/Federal Health Care Reform.

The federal government developed the SBC form primarily to help people who will be shopping for individual coverage. They are designed so that individuals can compare "apples to apples" when comparing plans. For that reason, we were not allowed to customize much of the SBC. Fortunately, you have coverage based on a Collective Bargaining Agreement between your employer(s) and your union.

ACA Requirements for SBCs - To best understand the benefits provided by this Fund, we recommend that you refer to the materials that the Fund maintains to help you. To view these documents please visit our website at <https://iuoelocal98.org/benefits/health-welfare/>, you will find the Summary Plan Description (SPD), and other documents that you are used to seeing.

The ACA has some very strict requirements for producing the SBCs - the maximum number of pages, the font size, the colors, etc. Also included in the SBC are three coverage examples - one for having a baby, one for managing type 2 diabetes, and one for a fracture. 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 is very important to note that these costs are national averages, they do not reflect what the actual services might cost you or your family. Similarly, your course of treatment might also be very different depending on your doctor's approach, whether your doctor is in-network or not (the examples show only in-network provider costs), your age, your other health issues, and many other factors. These examples are included to help 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", which the law does not allow to be customized for our Fund. If you read the SBC or the Glossary and find yourself confused at any time, we recommend that you refer to your SPD and the other materials describing your benefits that you may receive from the Fund.

Please keep the SBC with your SPD for easy reference. Receipt of this document does not constitute a determination of your eligibility. If you have any questions about Fund provided coverage, please call the Benefit Office at (413) 998-3230. 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.

Sincerely,


The Board of Trustees
I.U.O.E. Local 98 Health & Welfare Fund



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 the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see bluecrossma.org/coverage-info. 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 bluecrossma.org/sbcglossary or call 1-800-241-0803 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>\$300/individual; \$600/family.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. <u>Prescription drugs</u>, <u>emergency room care</u>, and the following <u>in-network</u> services: <u>primary care</u> and <u>specialist visits</u>, <u>preventive care</u>, <u>urgent care</u>, <u>outpatient mental health services</u>, <u>prenatal services</u>, <u>outpatient rehabilitation services</u>, <u>habilitation services</u>, and children's dental check-ups.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. \$50 dental <u>deductible</u> per individual per calendar year for basic and major services only (<u>in-network</u> and <u>out-of-network</u> combined).</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p><u>In-network</u> medical benefits: \$3,000/individual; \$6,000/family; <u>Out-of-network</u> medical benefits: No <u>out-of-pocket limit</u>; <u>Prescription drug</u> benefits: \$1,000/individual; \$2,000/family.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u>, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> 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 charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 (You will pay the least)	Out-of-Network (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 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u> plus charges above <u>allowed amount</u>	Includes telehealth benefits, <u>as applicable</u>
	<u>Specialist</u> visit	\$20 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u> plus charges above <u>allowed amount</u>	Limited to 12 acupuncture visits per calendar year; includes telehealth benefits, <u>as applicable</u>
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	20% <u>coinsurance</u>	Limited to age-based schedule and / or frequency; includes telehealth benefits, <u>as applicable</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required or benefits will be denied
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> may be required or benefits will be denied
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at bluecrossma.org/medication	Generic drugs	\$10 <u>copay</u> / retail supply or \$20 / mail service supply	Not covered	<u>Deductible</u> does not apply. Up to 30-day retail (90-day mail service) supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>preauthorization</u> required for certain drugs or benefits will be denied
	Preferred brand drugs	\$25 <u>copay</u> / retail supply or \$50 / mail service supply	Not covered	
	Non-preferred brand drugs	\$40 <u>copay</u> / retail supply or \$80 / mail service supply	Not covered	
	<u>Specialty drugs</u>	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; <u>preauthorization</u> required for certain drugs or benefits will be denied

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> / admission	20% <u>coinsurance</u> plus charges above <u>allowed amount</u>	<u>Preauthorization</u> required for certain services or benefits will be denied
	Physician/surgeon fees	No charge; <u>deductible</u> does not apply	20% <u>coinsurance</u> plus charges above <u>allowed amount</u>	<u>Preauthorization</u> required for certain services or benefits will be denied
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> / visit; <u>deductible</u> does not apply	\$100 / visit; <u>deductible</u> does not apply	<u>Copayment</u> waived if admitted or for observation stay
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> ; <u>deductible</u> does not apply	10% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	<u>Urgent care</u>	\$20 <u>copay</u> / visit; <u>deductible</u> does not apply	20% <u>coinsurance</u> plus charges above <u>allowed amount</u>	Includes telehealth benefits, as applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus charges above <u>allowed amount</u>	<u>Preauthorization</u> / authorization required for certain services or benefits will be denied
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus charges above <u>allowed amount</u>	<u>Preauthorization</u> / authorization required for certain services or benefits will be denied
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> / visit; <u>deductible</u> does not apply. No charge for intensive outpatient treatment and partial hospitalization; <u>deductible</u> does not apply	20% <u>coinsurance</u> plus charges above <u>allowed amount</u> for office visits, intensive outpatient treatment and partial hospitalization	Includes telehealth benefits, as applicable; <u>preauthorization</u> required for certain services or benefits will be denied
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus charges above <u>allowed amount</u>	<u>Preauthorization</u> / authorization required for certain services or benefits will be denied

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you are pregnant	Office visits	No charge for prenatal care; <u>deductible</u> does not apply. 10% <u>coinsurance</u> for postnatal care	20% <u>coinsurance</u> for prenatal care plus charges above <u>allowed amount</u> ; 30% <u>coinsurance</u> for postnatal care plus charges above <u>allowed amount</u>	<u>Cost sharing</u> does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); includes telehealth benefits, as applicable
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus charges above <u>allowed amount</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus charges above <u>allowed amount</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus charges above <u>allowed amount</u>	<u>Preauthorization</u> required or benefits will be denied
	<u>Rehabilitation services</u>	\$20 <u>copay</u> / visit for outpatient services; <u>deductible</u> does not apply. 10% <u>coinsurance</u> for inpatient services	20% <u>coinsurance</u> for outpatient services plus charges above <u>allowed amount</u> ; 30% <u>coinsurance</u> for inpatient services plus charges above <u>allowed amount</u>	Limited to 100 outpatient visits per calendar year (other than for autism, <u>home health care</u> , and speech therapy); limited to 60 days per calendar year for inpatient admissions; includes telehealth benefits, as applicable; <u>preauthorization</u> required for certain services or benefits will be denied
	<u>Habilitation services</u>	\$20 <u>copay</u> / visit	20% <u>coinsurance</u> plus charges above <u>allowed amount</u>	Outpatient rehabilitation therapy coverage limits apply; <u>cost share</u> and coverage limits waived for early intervention services for eligible children; includes telehealth benefits, as applicable
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus charges above <u>allowed amount</u>	Limited to 100 days per calendar year; <u>preauthorization</u> required or benefits will be denied
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus charges above <u>allowed amount</u>	<u>In-network cost share</u> waived for one breast pump per birth, including supplies (20% <u>coinsurance</u> for <u>out-of-network</u>)
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus charges above <u>allowed amount</u>	<u>Preauthorization</u> required for certain services or benefits will be denied
If your child needs dental or eye care	Children's eye exam	No charge; <u>deductible</u> does not apply	No charge up to \$100, then 100%; <u>deductible</u> does not apply	Limited to one exam every other calendar year. Separately administered by EyeMed.
	Children's glasses	No charge; <u>deductible</u> does not apply	No charge up to \$250, then 100%; <u>deductible</u> does not apply	Limited to one pair every other calendar year. Separately administered by EyeMed.
	Children's dental check-up	No charge; dental <u>deductible</u> does not apply	Charges above the <u>allowed amount</u> ; dental <u>deductible</u> does not apply	Limited to one check-up twice per calendar year. Separately administered by BCBSMA.

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.)

- Cosmetic surgery
- Long-term care
- Private-duty nursing

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

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger; \$1,000 per ear every 36 months, regardless of age)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (every other calendar year: one exam, one pair of glasses/contact lenses, and one pair of safety glasses for members)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$150 per calendar year per family unit for qualified weight loss programs; limit not applicable to ACA preventive services)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. 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. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact the I.U.O.E. Local 98 Health and Welfare Plan at 1-888-441-1922.

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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call Blue Cross Blue Shield of Massachusetts at 1-800-472-2689 or call the I.U.O.E. Local 98 Health and Welfare Plan at 1-888-441-1922. You may also contact The Office of Patient Protection at 1-800-436-7757 or www.mass.gov/hpc/opp. In addition, you may contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

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 prenatal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Delivery fee coinsurance</u>	10%
■ <u>Facility fee coinsurance</u>	10%
■ <u>Diagnostic tests coinsurance</u>	10%

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	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,300

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$1,670

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> visit <u>copay</u>	\$20
■ <u>Primary care</u> visit <u>copay</u>	\$20
■ <u>Diagnostic tests</u> <u>coinsurance</u>	10%

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	\$5,600
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,220

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist</u> visit <u>copay</u>	\$20
■ <u>Emergency room</u> <u>copay</u>	\$100
■ <u>Ambulance services</u> <u>coinsurance</u>	10%

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	\$2,800
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$90

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$290

The plan would be responsible for the other costs of these EXAMPLE covered services.

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