INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 98 BENEFIT FUNDS

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

KARA A. RICHOTTE
Fund Administrator

November 2023

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

Important Questions	Answers	Why This Matters:
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 (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 copay / visit; deductible does not apply	20% coinsurance plus charges above allowed amount	Includes telehealth benefits, as applicable
	Specialist visit	$20 copay / visit; deductible does not apply	20% coinsurance plus charges above allowed amount	Limited to 12 acupuncture visits per calendar year; includes telehealth benefits, as applicable
	Preventive care/screening/immunization	No charge; deductible does not apply	20% coinsurance	Limited to age-based schedule and / or frequency; includes telehealth benefits, as applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Preauthorization may be required or benefits will be denied
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization may be required or benefits will be denied
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at bluecrossma.org/medication	Generic drugs	$10 copay / retail supply or $20 / mail service supply	Not covered	Deductible does not apply. Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; preauthorization required for certain drugs or benefits will be denied
	Preferred brand drugs	$25 copay / retail supply or $50 / mail service supply	Not covered	
	Non-preferred brand drugs	$40 copay / retail supply or $80 / mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; preauthorization 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 copay / admission	20% coinsurance plus charges above allowed amount	Preauthorization required for certain services or benefits will be denied
	Physician/surgeon fees	No charge; deductible does not apply	20% coinsurance plus charges above allowed amount	Preauthorization required for certain services or benefits will be denied
If you need immediate medical attention	Emergency room care	$100 copay / visit; deductible does not apply	$100 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	10% coinsurance; deductible does not apply	10% coinsurance; deductible does not apply	None
	Urgent care	$20 copay / visit; deductible does not apply	20% coinsurance plus charges above allowed amount	Includes telehealth benefits, as applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance plus charges above allowed amount	Preauthorization / authorization required for certain services or benefits will be denied
	Physician/surgeon fees	10% coinsurance	30% coinsurance plus charges above allowed amount	Preauthorization / authorization required for certain services or benefits will be denied
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / visit; deductible does not apply. No charge for intensive outpatient treatment and partial hospitalization; deductible does not apply	20% coinsurance plus charges above allowed amount for office visits, intensive outpatient treatment and partial hospitalization	Includes telehealth benefits, as applicable; preauthorization required for certain services or benefits will be denied
	Inpatient services	10% coinsurance	30% coinsurance plus charges above allowed amount	Preauthorization / 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; deductible does not apply. 10% coinsurance for postnatal care	20% coinsurance for prenatal care plus charges above allowed amount; 30% coinsurance for postnatal care plus charges above allowed amount	Cost sharing does not apply for in-network preventive services; 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% coinsurance	30% coinsurance plus charges above allowed amount	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance plus charges above allowed amount	

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	Home health care	10% coinsurance	30% coinsurance plus charges above allowed amount	Preauthorization required or benefits will be denied
	Rehabilitation services	$20 copay / visit for outpatient services; deductible does not apply. 10% coinsurance for inpatient services	20% coinsurance for outpatient services plus charges above allowed amount; 30% coinsurance for inpatient services plus charges above allowed amount	Limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; includes telehealth benefits, as applicable; preauthorization required for certain services or benefits will be denied
	Habilitation services	$20 copay / visit; deductible does not apply	20% coinsurance plus charges above allowed amount	Outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; includes telehealth benefits, as applicable
	Skilled nursing care	10% coinsurance	30% coinsurance plus charges above allowed amount	Limited to 100 days per calendar year; preauthorization required or benefits will be denied
	Durable medical equipment	10% coinsurance	30% coinsurance plus charges above allowed amount	In-network cost share waived for one breast pump per birth, including supplies (20% coinsurance for out-of-network)
	Hospice services	10% coinsurance	30% coinsurance plus charges above allowed amount	Preauthorization required for certain services or benefits will be denied
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	No charge up to $100, then 100%; deductible does not apply	Limited to one exam every other calendar year. Separately administered by EyeMed.
	Children's glasses	No charge; deductible does not apply	No charge up to $250, then 100%; deductible does not apply	Limited to one pair every other calendar year. Separately administered by EyeMed.
	Children's dental check-up	No charge; dental deductible does not apply	Charges above the allowed amount; dental deductible 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) ($1,500 per member per calendar year; $1,000 lifetime for orthodontia)
- 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 plan's overall deductible**	**$300**
■ **Delivery fee coinsurance**	**10%**
■ **Facility fee coinsurance**	**10%**
■ **Diagnostic tests coinsurance**	**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**

In this example, Peg would pay:

Cost sharing	
Deductibles	$300
Copayments	$10
Coinsurance	$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 plan's overall deductible**	**$300**
■ **Specialist visit copay**	**$20**
■ **Primary care visit copay**	**$20**
■ **Diagnostic tests coinsurance**	**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**

In this example, Joe would pay:

Cost sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$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 plan's overall deductible**	**$300**
■ **Specialist visit copay**	**$20**
■ **Emergency room copay**	**$100**
■ **Ambulance services coinsurance**	**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**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$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.