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?	$0	See Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	See Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. Home Health Care: $50 per person when care is rendered without prior hospitalization or through a non-participating agency.	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?	Not Applicable.	See Common Medical Events chart below for your costs for services this plan covers.
What is not included in the out-of-pocket limit?	Not Applicable.	See Common Medical Events chart below for your costs for services this plan covers.
Will you pay less if you use a network provider?	Yes. For a list of all network providers, see www.Local94.com or call 1-212-541-9880.	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). See Common Medical Events chart below.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	Clinics are not covered. There is no network. All benefits are paid based on a Schedule of Allowance.
	Specialist visit	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	Clinics are not covered. There is no network. All benefits are paid based on a Schedule of Allowance.
	Preventive care/screening/immunization (You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive)	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	Clinics are not covered. There is no network. All benefits are paid based on a Schedule of Allowance. Subject to frequency and age limits.
If you have a test	Diagnostic test (x-ray, blood work)	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	There is no network. All benefits are paid based on a Schedule of Allowance
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	There is no network. All benefits are paid based on a Schedule of Allowance. CT scan not covered unless the services are provided in a facility approved under the New York State Public Health Plan, or comparable state authority outside of New York State.

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.optumrx.com**	Generic drugs	Retail: $10 copay/prescription (30-day supply); Mail order: $20 copay/prescription (90-day supply)	Not covered	Plan includes mandatory generic substitution policy, only two refills are available at retail then you must use OPTUM Rx home delivery or CVS90 Saver program at a CVS Pharmacy location for maintenance medications with a 90 day supply.
	Formulary brand drugs	20% coinsurance (retail & mail order), max $40/prescription	Not covered	
	Non-formulary brand drugs	40% coinsurance (retail & mail order), max $60/prescription	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	Amounts over Schedule of Allowance	Clinics are not covered.
	Physician/surgeon fees	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	Includes surgeon, surgical assistant and anesthesia. There is no network. All benefits are paid based on a Schedule of Allowance.
If you need immediate medical attention	Emergency room care	No charge	No charge	30 visits/treatments per calendar year when provided in the emergency room or outpatient department of a participating hospital. Clinics are not covered
	Emergency medical transportation	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	Clinics are not covered. There is no network. All benefits are paid based on a Schedule of Allowance.
	Urgent care	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	Clinics are not covered. There is no network. All benefits are paid based on

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)	
				a Schedule of Allowance.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge first 120 days; 50% coinsurance for the next 180 day reserve periods	Inside Empire Service Area: the first 120 days at 20%, next 180 day reserve period at 40%. Outside Empire's service area, the first 120 days at 20% coinsurance after first $15/day; next 180 day reserve period at 40% coinsurance after first $7.50/day	Inpatient Services: Limited to 300 days per calendar year which are included in the inpatient hospital days.
	Physician/surgeon fees	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	There is no network. All benefits are paid based on a Schedule of Allowance
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Facility: No charge	No charge	Clinics are not covered.
		Mental Health Care: Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	There is no network. All benefits are paid based on a Schedule of Allowance.
	Inpatient services	No charge first 120 days; 50% coinsurance for the next 180 day reserve periods	Inside Empire Service Area: the first 120 days at 20%, next 180 day reserve period at 40%. Outside Empire's service area, the first 120 days at 20% coinsurance after first $15/day; next 180 day reserve period at 40% coinsurance after first $7.50/day	Inpatient Services: Limited to 300 days per calendar year which are included in the inpatient hospital days.
If you are pregnant	Office visits	Amounts over Schedule of Allowance	Amounts over Schedule of Allowance	There is no network. All benefits are paid based on a Schedule of Allowance
	Childbirth/delivery professional services	Amounts over Schedule of	Amounts over Schedule of	There is no network. All benefits are

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)	
		Allowance	Allowance	paid based on a Schedule of Allowance
	Childbirth/delivery facility services	Facility: No charge first 120 days; 50% coinsurance for the next 180 day reserve periods	Inside Empire Service Area: the first 120 days at 20%, next 180 day reserve period at 40%. Outside Empire's service area, the first 120 days at 20% coinsurance after first $15/day; next 180 day reserve period at 40% coinsurance after first $7.50/day	Inpatient Services: Limited to 300 days per calendar year which are included in the inpatient hospital days.
If you need help recovering or have other special health needs	Home health care	No charge	$50 deductible; 25% coinsurance plus balance bill when care is rendered without prior hospitalization or care begins after 7 days of discharge from the hospital	Participating: Maximum 200 visits per calendar year when care begins within 7 days of discharge from hospital. Non-Participating: 40 visits per calendar year.
	Rehabilitation services	No charge first 120 days; 50% coinsurance for the next 180 day reserve periods	Inside Empire Service Area: the first 120 days at 20%, next 180 day reserve period at 40%. Outside Empire's service area, the first 120 days at 20% coinsurance after first $15/day; next 180 day reserve period at 40% coinsurance after first $7.50/day	Inpatient Services: Limited to 300 days per calendar year which are included in the inpatient hospital days.
	Habilitation services	No charge first 120 days; 50% coinsurance for the next 180 day reserve periods	Inside Empire Service Area: the first 120 days at 20%, next 180 day reserve period at 40%. Outside Empire's service area, the first 120 days at 20% coinsurance after first $15/day; next 180 day reserve period at 40% coinsurance after first $7.50/day	

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)	
	Skilled nursing care	Not covered	Not covered	You must pay 100% of these expenses, even In-Network.
	Durable medical equipment	Not covered	Not covered	You must pay 100% of these expenses. Exception: CPAP machine covered (the benefit allowance schedule applies).
	Hospice services	No charge	No charge	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.

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; as medically necessary)
- Durable medical equipment (exception CPAP machine, benefit allowance schedule applies)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Skilled nursing 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 (member and spouse only)
- Dental care (Adult) (Benefit allowance schedule applies)
- Emergency medical transportation
- 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)

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

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; OptumRX 1-855-295-9140; Health & Benefit Fund Office for all other services 212-541-9880.

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Empire Blue Cross 1-800-553-9603; OPTUM Rx 1-855-295-9140; 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; OPTUM Rx 1-855-295-9140; 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; OPTUM Rx 1-855-295-9140; 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 **plan's**. Please note these coverage examples are based on self-only coverage.

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

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

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
*Deductibles	N/A
*Copayments	N/A
*Coinsurance	N/A
What isn't covered	
*Limits or exclusions	N/A
***The total Peg would pay is**	**N/A**

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

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

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
*Deductibles	N/A
*Copayments	N/A
*Coinsurance	N/A
What isn't covered	
*Limits or exclusions	N/A
***The total Joe would pay is**	**N/A**

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

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

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
*Deductibles	N/A
*Copayments	N/A
*Coinsurance	N/A
What isn't covered	
*Limits or exclusions	N/A
***The total Mia would pay is**	**N/A**

*Hospital services provided within the Empire service area and all prescription drug benefits must be obtained through in-network providers. However, there is no network of providers for medical benefits under this Plan. The Plan pays for covered hospital and medical services based on a fixed schedule of allowance, unless stated otherwise.