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, 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 Live Health-On-Line	$20 copay/visit $15 copay/visit	Deductible and 20% coinsurance + balance billing Not Covered	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: 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.optumrx.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 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	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 billing	

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)	
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 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	Deductible and 20%	Failure to precertify may result in a

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)	
		copay/visit Inpatient facility: No charge	coinsurance + balance billing	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.

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 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, 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.
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 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 1-844-241-7089; OPTUM Rx 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 Cross1-844-241-7089; OPTUM Rx 1-855-295-9140; 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

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Empire Blue Cross1-844-241-7089; 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 1-844-241-7089; 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 **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$900
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$980**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$30
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$1,380**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**