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?	$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?	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 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.

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 CVS Virtual Care	No Charge No Charge	Subject to balance billing Not Covered	
	Specialist visit	No Charge	Subject to balance billing	
	Preventive care/screening/ Immunization (You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive)	No Charge	Subject to balance billing	Annual physical available In-network only. Subject to frequency and age limitations.
If you have a test	Diagnostic test	No Charge	Subject to balance billing	
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	No Charge	Subject to 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.cvs.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. Maintenance medications: Only two refills are available at retail then you must receive a 90-day supply from the maintenance choice program and the select pharmacies included: Costco and their mail pharmacies, Kroger affiliated pharmacies and their pharmacies, CVS affiliated pharmacies, CVS Caremark® Mail Service Pharmacy.
	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), $150/prescription (per 90-day supply)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Subject to balance billing	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fees	No Charge	Subject to balance billing	Failure to precertify may result in a reduction or no benefits.
If you need immediate medical attention	Emergency room care	No Charge	No Charge	No coverage for non-emergency use of Emergency Room Care.
	Emergency medical transportation	No Charge	Subject to balance billing	
	Urgent care	No Charge	Subject to balance billing	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Subject to balance billing	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fees	No Charge	Subject to balance billing	Failure to precertify 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 mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Subject to balance billing	
	CVS Virtual Care	No Charge	Not Covered	
	Inpatient services	No Charge	Subject to balance billing	Failure to precertify may result in a reduction or no benefits.
If you are pregnant	Office visits	No Charge	Subject to balance billing	
	Childbirth/delivery professional services	No Charge	Subject to balance billing	Failure to precertify may result in a reduction or no benefits.
	Childbirth/delivery facility services	No Charge	Subject to balance billing	
If you need help recovering or have other special health needs	Home health care	No Charge	Subject to 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: Not Covered Inpatient facility: No Charge	Not Covered Subject to 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: Covered Inpatient facility: No Charge	Subject to balance billing	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	You must pay 100% of these expenses. Exception: CPAP machine covered.
	Hospice services	No Charge	No Charge	Up to 210 days per lifetime.

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 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.)

- 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.)

- Acupuncture (up to 12 visits maximum per year)
- Bariatric surgery (to treat morbid obesity as medically necessary)
- Chiropractic care (member and spouse only)
- Dental care (Adult) (Benefit allowance schedule applies)
- Routine eye care (Adult)
- Hearing aids (per ear once every 3 years, Benefit allowance schedule applies)
- Infertility treatment (There is a separate lifetime maximum for the female individual (participant or spouse) and for the male individual (participant or spouse) of $12,500 subject to the applicable 20% coinsurance. Infertility prescriptions are part of this lifetime maximum for the female individual (participant or spouse) and for the male individual (participant or spouse); however, the participant must submit prescription claims to the Fund Office. Once received, the Fund Office will submit the prescription claims to Aetna for processing).

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 Aetna 833-821-0799; CVS/Caremark 833-269-9417; 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 Aetna 833-821-0799; CVS/Caremark 833-269-9417; 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 Aetna 833-821-0799; CVS/Caremark 833-269-9417; 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 Aetna 833-821-0799; CVS/Caremark 833-269-9417; 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
*Deductibles	N/A
*Copayments	$10
*Coinsurance	N/A
What isn't covered	
*Limits or exclusions	$60
***The total Peg would pay is**	**$70**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
*Deductibles	N/A
*Copayments	$510
*Coinsurance	N/A
What isn't covered	
*Limits or exclusions	$20
***The total Joe would pay is**	**$530**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
*Deductibles	N/A
*Copayments	$10
*Coinsurance	N/A
What isn't covered	
*Limits or exclusions	$610
***The total Mia would pay is**	**$620**