

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Health & Benefit Trust Fund of the IUOE Local 94-94A-94B Fund

School Division: Active & Non-Medicare Retirees; Aetna Choice POS II & Caremark SC ACSF

Coverage Period: 01/01/2025 – 12/31/2025


Coverage for: Individual + Family | Plan Type: POS



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, <u>preventive care</u> and for those benefits that are administered by the Fund Office. <u>Balance billing</u> , excluded services, <u>copayments</u> and <u>coinsurance</u> do not count toward the <u>deductible</u> .	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> . Reminder: <u>Deductible</u> only applies to <u>out-of-network providers</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	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.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> 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 <u>network providers</u> .	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>).
Do you need a referral to see a specialist?	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 Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	CVS Virtual Care	\$15 <u>copay</u> /visit	<u>Not Covered</u>	
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	<u>Preventive care/screening/immunizations</u> . (You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive)	<u>Preventive care and screening</u> (Adult): \$20 <u>copay</u> /visit Immunizations (Adult): 20% <u>coinsurance</u> Well-child: No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Annual physical available In-Network only. Subject to frequency and age limits.
If you have a test	<u>Diagnostic test</u>	X-ray: 20% <u>coinsurance</u> Blood work: No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.cvs.com</p>	Generic drugs	Retail: \$5 <u>copay</u> /prescription (30-day supply). Mail Order: \$10 <u>copay</u> /prescription (90-day supply).	Not covered	<p><u>Plan</u> includes mandatory generic substitution policy.</p> <p>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 mail pharmacies, CVS affiliated pharmacies, CVS Caremark® Mail Service Pharmacy.</p>
	Formulary brand drugs	Retail: \$15 <u>copay</u> /prescription (30-day supply). Mail Order: \$25 <u>copay</u> /prescription (90-day supply).	Not covered	
	Non-formulary brand drugs	Retail: \$15 <u>copay</u> /prescription (30-day supply). Mail Order: \$25 <u>copay</u> /prescription (90-day supply).	Not covered	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> , max \$50/prescription (per 30-day supply), \$150/prescription (per 90-day supply)	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
<p>If you need immediate medical attention</p>	Emergency room care	\$50 <u>copay</u> /visit, waived if admitted within 24 hours	\$50 <u>copay</u> /visit, waived if admitted within 24 hours	No coverage for non-emergency use of Emergency Room Care.
	Emergency medical transportation	20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	Urgent care	\$20 <u>copay</u> /visit	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Urgent Care: In-Network <u>copay</u> applies to office visit only, no coverage for non-urgent use.

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	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	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 <u>copay</u> /visit.	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	CVS Virtual Care	\$15 Copay		
	Inpatient services	No Charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
If you are pregnant	Office visits	\$20 <u>copay</u> /initial visit then 20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	Childbirth/delivery facility services	No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
If you need help recovering or have other special health needs	Home health care	No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Up to 200 visits per calendar year (a visit equals 4 hours of care) In-Network and Out-of-Network combined.

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 help recovering or have other special health needs (continued)	Rehabilitation services	Outpatient visit: \$20 <u>copay</u> /visit Inpatient facility: No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	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: \$20 <u>copay</u> /visit Inpatient facility: No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	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% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
	Hospice services	No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	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 <u>copay</u> /exam for Sele-Dent <u>providers</u>	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 .)		
<ul style="list-style-type: none"> Cosmetic surgery (except as medically necessary) 	<ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> 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.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none">• Acupuncture (up to 12 visits maximum per year).• Bariatric surgery (to treat morbid obesity as medically necessary)• 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) | <ul style="list-style-type: none">• 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 20% <u>coinsurance</u>. 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 [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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$900
<i>What isn't covered</i>	
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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$30
<i>What isn't covered</i>	
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:

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