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, co-insurance, 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 the Common Medical Events below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	See the Common Medical Events below for your costs for services this plan covers.
Are there other deductibles for specific services?	Not Applicable.	See the Common Medical Events below for your costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Not Applicable.	See the Common Medical Events below for your costs for services this plan covers.
What is not included in the out-of-pocket limit?	Not Applicable.	See the Common Medical Events below for your costs for services this plan covers.
Will you pay less if you use a network provider?	Not Applicable.	See the Common Medical Events below for your costs for services this plan covers.
Do you need a referral to see a specialist?	Not Applicable.	See the Common Medical Events below for your costs for services this plan covers.

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	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.
	Specialist visit	Not Applicable	Not Applicable	
	Preventive care/screening/ immunization	Not Applicable	Not Applicable	
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	Not Applicable	Not Applicable	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.optumrx.com**	Generic drugs	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.
	Formulary brand drugs	Not Applicable	Not Applicable	
	Non-formulary brand drugs	Not Applicable	Not Applicable	
	Specialty drugs	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.
	Physician/surgeon fees	Not Applicable	Not Applicable	
If you need immediate medical attention	Emergency room care	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member
	Emergency medical transportation	Not Applicable	Not Applicable	

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)	
	Urgent care	Not Applicable	Not Applicable	and spouse maximum of $7,000/year.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.
	Physician/surgeon fees	Not Applicable	Not Applicable	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.
	Inpatient services	Not Applicable	Not Applicable	
If you are pregnant	Office visits	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.
	Childbirth/delivery professional services	Not Applicable	Not Applicable	
	Childbirth/delivery facility services	Not Applicable	Not Applicable	
If you need help recovering or have other special health needs	Home health care	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.
	Rehabilitation services	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.
	Habilitation services	Not Applicable	Not Applicable	
	Skilled nursing care	Not Applicable	Not Applicable	
	Durable medical equipment	Not Applicable	Not Applicable	
	Hospice services	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	Not Applicable	Not Applicable	This plan only reimburses the Medicare Part B and Part D premiums to a combined member
	Children's glasses	Not Applicable	Not Applicable	

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)	
	Children's dental check-up	Not Applicable	Not Applicable	and spouse maximum of $7,000/year.

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
- Bariatric surgery
- Chiropractic care
- Clinics
- Cosmetic Surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

This Plan only reimburses Medicare Part B and Part D premiums to a combined member and spouse maximum $7,000/year.

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? No

This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year. 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? No.

This plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year. 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.

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

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; 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 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 Rx1-855-295-9140; 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.*

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 **co-insurance**) 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** **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**

This Plan only reimburses the Medicare Part B and Part D premiums to a combined member and spouse maximum of $7,000/year.