

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

Coverage Period: 01/01/2020 – 12/31/2020


Coverage for: Individual + Family | Plan Type: PPO



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?	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. <u>Balance billing</u> , <u>excluded services</u> , <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. Preventive care 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</u> charge 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>	Clinics are not covered.
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	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 <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. Clinics are not covered.
If you have a test	<u>Diagnostic test (x-ray, blood work)</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.optumrx.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, 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.</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),	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	<p>Urgent Care: In-Network <u>copay</u> applies to office visit only</p>
	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>	

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	<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>	Clinics are not covered.
	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.
	Rehabilitation services	Outpatient visit: \$20	<u>Deductible</u> and 20%	Failure to precertify may result in a

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*	
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)		
		<u>copay/visit</u> Inpatient facility: No charge	<u>coinsurance + balance billing</u>	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/visit</u> Inpatient facility: No charge	<u>Deductible and 20% coinsurance + 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 and 20% coinsurance + balance billing</u>		Failure to precertify may result in a reduction or no benefits.
	Hospice services	No charge	<u>Deductible and 20% coinsurance + 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/exam</u> 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](#).)

- 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 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; 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.

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 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 [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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$520
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$610

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$870
Coinsurance	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Joe would pay is	\$970

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$400