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 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?	Yes. For a list of all network providers, see www.Local94.com or call 1-212-541-9880.	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?	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	No charge	Amounts over the Medicare fee schedule.	The Plan pays secondary to Medicare. The Plan only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts.
	Specialist visit	No charge	Amounts over the Medicare fee schedule.	
	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	Amounts over the Medicare fee schedule.	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Amounts over the Medicare fee schedule.	The Plan pays secondary to Medicare. The Plan only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	No charge	Amounts over the Medicare fee schedule.	

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.UHCRetiree.com**	Generic drugs	Retail: $10 copay/prescription (30-day supply). Mail order: $20 copay/prescription (90-day supply)	If you use out of network pharmacies, the plan may not pay for those drugs or you may pay more than you pay at a network pharmacy.	Your Plan has UnitedHealth Care® MedicareRx℠ for your prescription drug coverage. This plan is also known as a Medicare Part D plan. The plan's drug list (formulary includes all of the drugs covered by Medicare Part D in brand or generic form. Your plan has access to pharmacies in the UnitedHealth Care network. You may fill your 90-day maintenance medication at a CVS retail pharmacy or by mail with OptumRx® Home Delivery, you can also utilize any other pharmacies in United Healthcare's retail network that fill 90-day supplies.
	Formulary brand drugs	Retail and Mail order; 20% coinsurance to maximum $40/prescription	If you use out of network pharmacies, the plan may not pay for those drugs or you may pay more than you pay at a network pharmacy.	
	Non-formulary brand drugs	Retail and Mail order; 40% coinsurance to maximum $60/prescription	If you use out of network pharmacies, the plan may not pay for those drugs or you may pay more than you pay at a network pharmacy.	
	Specialty drugs	20% coinsurance to maximum $50/prescription (per 30 day supply)	If you use out of network pharmacies, the plan may not pay for those drugs or you may pay more than you pay at a network pharmacy.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Amounts over the Medicare fee schedule	The Plan pays secondary to Medicare. The Plan only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts
	Physician/surgeon fees	No charge	Amounts over the Medicare fee schedule	
If you need immediate medical attention	Emergency room care	No charge	Amounts over the Medicare fee schedule	The Plan pays secondary to Medicare. The Plan only covers services or

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)	
	Emergency medical transportation	No charge	Amounts over the Medicare fee schedule	supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts
	Urgent care	No charge	Amounts over the Medicare fee schedule	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge through 91st day and for 60-day Medicare lifetime reserve; thereafter, 50% coinsurance for days 91st to 201st day after the 60 Medicare lifetime reserve days are exhausted plus amounts over Medicare fee schedule.	Amounts over the Medicare fee schedule	The Plan pays secondary to Medicare. The Plan only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts
	Physician/surgeon fees	No charge	Amounts over the Medicare fee schedule	

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	Amounts over the Medicare fee schedule	The Plan pays secondary to Medicare. The Plan only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts
	Inpatient services	No charge through 91st day and for 60-day Medicare lifetime reserve; thereafter, 50% coinsurance for days 91st to 201st day after the 60 Medicare lifetime reserve days are exhausted plus amounts over Medicare fee schedule.	Amounts over the Medicare fee schedule	
If you are pregnant	Office visits	No charge	Amounts over the Medicare fee schedule	The Plan pays secondary to Medicare. The Plan only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts
	Childbirth/delivery professional services	No charge	Amounts over the Medicare fee schedule	
	Childbirth/delivery facility services	No charge through 91st day and for 60-day Medicare lifetime reserve; thereafter, 50% coinsurance for days 91st to 201st day after the 60 Medicare lifetime reserve days are exhausted plus amounts over Medicare fee schedule.	Amounts over the Medicare fee schedule	

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	Home health care	Not covered	Not covered	The Plan pays secondary to Medicare. The Plan only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts
	Rehabilitation services	No Charge	Amounts over Medicare fee schedule	
	Habilitation services	No Charge	Amounts over Medicare fee schedule	
	Skilled nursing care	No charge	Not covered	
	Durable medical equipment	No Charge	Amounts over Medicare fee schedule	
	Hospice services	Not covered	Not covered	
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 over $50	One pair of glasses per calendar year
	Children's dental check-up	No Charge for Fund panel dentists;$15 co-pay/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 the "Medicare and You" handbook or the Plan's SPD document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Clinics
- Cosmetic Surgery
- Infertility treatment 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.)

- Dental care (Adult) (Benefit allowance schedule applies)
- Hearing aids (per ear once every 3 years) (Benefit allowance schedule applies)
- 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? No.

This Plan only pays secondary to Medicare with the exception of Prescription Drugs. 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? No.

This Plan only pays secondary to Medicare with the exception of Prescription Drugs. 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 Cross1-844-241-7089; UnitedHealth Care® MedicareRx℠ 1-866-691-8209 ; 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 1-844-241-7089; UnitedHealth Care® MedicareRx℠ 1-866-691-8209; 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 Cross1-844-; UnitedHealth Care® MedicareRx℠ 1-886-691-8209; 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;UnitedHealth Care® MedicareRx℠ 1-866-691-8209; 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 **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** — **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	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	**$5,600**
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	**$2,800**
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 pays secondary to Medicare with the exception of Prescription Drugs, Dental and Eye Care. The Plan only covers services or supplies that are covered by Medicare, to the extent that Medicare covers them, up to the Medicare allowance. The Plan reimburses amounts of Medicare cost-sharing (deductibles, coinsurance). No coverage for providers who have opted out of Medicare and entered into private contracts.