

**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

Commercial Division: Active & PPO Retirees


Coverage Period: 01/01/2021 – 12/31/2021  
 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 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](http://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](http://www.dol.gov/ebsa/healthreform) or call 1-212-541-9880 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In-Network & Out-of-Network combined: \$100 person/\$400 family. Doesn't apply to emergency room, exams/evaluations, preventive care, prescription drugs and for those benefits that are administered by the Fund Office. <u>Balance billing</u> , excluded services, <u>copayments</u> & <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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.Local94.com">www.Local94.com</a> 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> ).
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	Clinics are not covered.
	Live Health-On-Line	\$15 <a href="#">copay</a> /visit	<a href="#">Not Covered</a>	
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	Clinics are not covered.
	Preventive care/screening/ Immunization (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 <a href="#">copay</a> /visit,  Immunizations (adult) - <a href="#">Deductible</a> & 20% <a href="#">coinsurance</a> ; Well-child - No charge	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	Annual physical available In-Network only. Subject to frequency and age limits. Clinics are not covered.
<b>If you have a test</b>	<a href="#">Diagnostic test (x-ray, blood work)</a>	X-ray: <a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> Blood work: \$15 <a href="#">copay</a> /visit	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	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)	
<b>If you need drugs to treat your illness or condition</b>  <b>More information about prescription drug coverage is available at <a href="http://www.optumrx.com">www.optumrx.com</a></b>	Generic drugs	Retail: \$10 <u>copay</u> /prescription (30-day supply); Mail order: \$20 <u>copay</u> /prescription (90-day supply)	Not covered	<u>Plan</u> includes mandatory generic substitution policy, only two refills are available at retail then you must use OptumRx home delivery or CVS90 Saver program at a CVS Pharmacy location for maintenance medications with a 90 day supply.
	Formulary brand drugs	20% <u>coinsurance</u> (retail & mail order), max \$40/prescription	Not covered	
	Non-formulary brand drugs	40% <u>coinsurance</u> (retail & mail order), max \$60/prescription	Not covered	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> , max \$50/prescription (per 30-day supply)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Deductible and 20% <u>coinsurance</u> + <u>balance billing</u>	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fees	<u>Deductible</u> and 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.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$70 <u>copay</u> /visit, waived if admitted within 24 hours	\$70 <u>copay</u> /visit, waived if admitted within 24 hours	Urgent Care: In-Network <u>copay</u> applies to office visit only.
	<a href="#">Emergency medical transportation</a>	<u>Deductible</u> and 20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
	<a href="#">Urgent care</a>	\$40 <u>copay</u> /visit	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	
<b>If you have a hospital stay</b>	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	<u>Deductible</u> and 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.

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Substance Abuse Care: No charge Mental Health Care: Doctor Service (outpatient/office visit) \$40 <u>copay</u> /visit.	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Clinics are not covered.
	LiveHealth Online	\$15 Copay	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.
<b>If you are pregnant</b>	Office visits	\$20 <u>copay</u> /initial visit then <u>deductible</u> and 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	<u>Deductible</u> and 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>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	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.
	<a href="#">Rehabilitation services</a>	Outpatient visit: \$40 <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.
	<a href="#">Habilitation services</a>	Outpatient Visit: \$40 <u>copay</u> /visit Inpatient facility: No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	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

For more information about limitations and exceptions, see [plan](#) or policy document at [www.local94.com](http://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)	
	<a href="#">Skilled nursing care</a>	No charge	Not covered	combined). Failure to precertify may result in a reduction or no benefits. Up to 60 days per calendar year.
	<a href="#">Durable medical equipment</a>	<u>Deductible</u> and 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.
	<a href="#">Hospice services</a>	No charge	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	Up to 210 days per lifetime.
<b>If your child needs dental or eye care</b>	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](#).)**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture (except in limited circumstances up to 12 visits maximum per year)</li> <li>• Bariatric surgery (except to treat morbid obesity as medically necessary)</li> <li>• Clinics</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic surgery (except reconstructive surgery related to functional defect present since birth or post-mastectomy; precertification required)</li> <li>• Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|--|---|---|

**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"> <li>• Chiropractic care (Maximum 20 visits per calendar year; In-Network and Out-of-Network combined; covered for member and spouse only)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Adult) (Benefit allowance schedule applies)</li> <li>• Hearing aids (Per ear once every 3 years) (Benefit allowance schedule applies)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment (Limited to member and spouse up to \$12,500 combined between member and spouse lifetime maximum including drugs, subject to 20% coinsurance)</li> <li>• Routine eye care (Adult)</li> </ul> |
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**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](http://www.dol.gov/ebsa/healthreform), U.S. Department of Health and Human Services at 1-877-267-2323x61565 or [www.cciio.cms.gov](http://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](http://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 44<sup>th</sup> 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](http://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 Empire Blue Cross 1 844 241 7089; OptumRX 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 1 844 241 7089; OptumRX 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 1 844 241 7089; OptumRX 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 1 844 241 7089; OptumRX 1-855-295-9140; Health & Benefit Fund Office 212-541-9880 for all other services.

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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**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](#) \$100
- [Specialist copayment](#) \$40
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$100
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,160</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$40
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$600
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Joe would pay is</b>	<b>\$1,700</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$40
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$300
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>