

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

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

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

Coverage Period: 01/01/2026 – 12/31/2026

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](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:
What is the overall <u>deductible</u> ?	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 <u>deductible</u> ?	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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	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 <u>out-of-pocket limit</u> ?	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 <u>network provider</u> ?	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> ).
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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*
		<a href="#">In-Network Provider</a> (You will pay the least)	<a href="#">Out-of-Network Provider</a> (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	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>	
	CVS Virtual Care	\$15 <a href="#">copay</a> /visit	Not Covered	
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit	<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.
	<a href="#">Preventive care/screening</a> /immunizations. (You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive)	<a href="#">Preventive care and screening</a> (Adult): \$20 <a href="#">copay</a> /visit  Immunizations (Adult): 20% <a href="#">coinsurance</a>  Well-child: No charge	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	
If you have a test	<a href="#">Diagnostic test</a>	X-ray: 20% <a href="#">coinsurance</a> Blood work: No charge	<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.
	Imaging (CT/PET scans, MRIs/MRAs, Nuclear Stress Test and Echocardiogram)	20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> and 20% <a href="#">coinsurance</a> + <a href="#">balance billing</a>	

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		<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 drugs to treat your illness or condition</b>  <b>More information about prescription drug coverage is available at <a href="http://www.cvs.com">www.cvs.com</a></b>	Generic drugs	Retail: \$5 <u>copay</u> /prescription (30-day supply). Mail Order: \$10 <u>copay</u> /prescription (90-day supply).	Not covered	<u>Plan</u> includes mandatory generic substitution policy.  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.
	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	
<b>If you have outpatient surgery</b>	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.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$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.
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	<u>Deductible</u> and 20% <u>coinsurance</u> + <u>balance billing</u>	

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="#">Urgent care</a>	\$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.
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>	



## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Cosmetic surgery (except as medically necessary)</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><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 <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Acupuncture (up to 12 visits maximum per year).</li><li>• Bariatric surgery (to treat morbid obesity as medically necessary)</li><li>• Chiropractic care (Maximum 20 visit per calendar year; In-Network and Out-of-Network combined; covered for member and spouse only)</li><li>• Dental care (Adult) (Benefit allowance schedule applies)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Hearing aids (Per ear once every 3 years) (Benefit allowance schedule applies)</li><li>• 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% <a href="#">coinsurance</a>. Infertility</li></ul>	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](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 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.

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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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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$980</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$30
What isn't covered	
Limits or exclusions	\$50
<b>The total Joe would pay is</b>	<b>\$1,380</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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:

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