Health & Benefit Trust Fund of the IUOE Local 94-94A-94B Fund
School Division: Actives

Coverage Period:01/01/2013 - 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or Plan Document at www.Local94.com or by calling 1-212-541-9880.

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. Balance billing, excluded services, co-payments and co-insurance do not count toward the deductible.	You must pay all the costs up to the deductible amount before this Plan begins to pay for covered services you use. Check the Plan's Summary Plan Description ("SPD") to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this Plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This Plan has no out-of-pocket limit.	Not applicable because there's no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the Plan pays?	No.	The chart starting on page 2 describes any limits on what the Plan will pay for specific covered services, such as office visits.

Questions: Call 1-212-541-9880 or visit us at www.Local94.com.
If you aren't clear about any of the bolded terms used in this form, 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:
Does this Plan use a network of providers?	Yes. For a list of all network **providers**, see www.Local94.com or call 1-212-541-9880.	If you use an in-network doctor or other health care provider, this Plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this Plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this Plan.
Are there services this Plan doesn't cover?	Yes.	Some of the services this Plan doesn't cover are listed on page 6. See the Plan's SPD for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the Plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the Plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This Plan may encourage you to use providers by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	Deductible and 20% coinsurance + balance billing	Clinics are not covered.
	Specialist visit	$20 co-pay/visit	Deductible and 20% coinsurance + balance billing	Clinics are not covered.
	Other practitioner office visit	$20 co-pay/visit	Deductible and 20% co-insurance + balance billing	Chiropractic limited to 20 visits per calendar year (In-Network and Out-of-Network combined). Clinics are not covered.
	Preventive care/screening/immunization	Preventive care and screening (adult) - $20 co-pay/visit, Immunizations (adult) - 20% coinsurance; Well-child - No charge	Deductible and 20% co-insurance + balance billing	Annual physical available In-Network only. Subject to frequency and age limits. Clinics are not covered.

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance for x-ray, no charge for lab	Deductible and 20% co-insurance + balance billing	-- None --
	Imaging (CT/PET scans, MRIs)	20% co-insurance	Deductible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	Retail: $5 co-pay (30-day supply)/script; Mail order: $10 co-pay (90-day supply)/script	Not covered	Plan includes mandatory generic substitution policy, only two refills are available at retail and then must use mail order pharmacy or CVS pharmacy for maintenance choice at a CVS retail store.
	Formulary brand drugs	Retail: $15 co-pay (30-day supply)/script; Mail order: $25 co-pay (90-day supply)/script	Not covered	
	Non-formulary brand drugs	Retail: $15 co-pay (30-day supply)/script; Mail order: $25 co-pay (90-day supply)/script	Not covered	
	Specialty drugs	20% co-insurance, max $50 per 30-day supply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Deducible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fees	20% co-insurance	Deductible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits.
If you need immediate medical attention	Emergency room services	$50 co-pay, waived if admitted within 24 hours	$50 co-pay, waived if admitted within 24 hours	-- None --
	Emergency medical transportation	20% co-insurance	Deductible and 20% co-insurance + balance billing	-- None --
	Urgent care	$20 co-pay/visit	Deductible and 20% co-insurance + balance billing	In-Network co-pay applies to office visit only.

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Deductible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Physician/surgeon fee	20% co-insurance	Deductible and 20% co-insurance + balance billing	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/visit	Deductible and 20% co-insurance + balance billing	Clinics are not covered.
	Mental/Behavioral health inpatient services	No charge	Deductible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Substance Use disorder outpatient services	No charge	Deductible and 20% co-insurance + balance billing	Clinics are not covered.
	Substance Use disorder inpatient services	Detoxification: No charge Inpatient: No charge	Detoxification: Deductible and 20% co-insurance + balance billing Inpatient: Deductible and 20% co-insurance + balance billing	Detoxification: Failure to precertify may result in a reduction of benefits. Inpatient: Failure to precertify may result in a reduction or no benefits.
If you are pregnant	Prenatal and postnatal care	$20 co-pay/initial visit then 20% co-insurance	Deductible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Delivery and all inpatient services	No charge for facility, 20% co-insurance for physician charges for delivery	Deductible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits.

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Deductible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits. Up to 200 visits per calendar year (a visit equals 4 hours of care) In-Network and Out-of-Network combined.
	Rehabilitation services	$20 co-pay/outpatient visit; No charge for inpatient facility	Deductible and 20% coinsurance + balance billing	Failure to precertify may result in a 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). Speech and occupational therapy covered outpatient only subject to 30 visits per calendar year limit.
	Habilitation services	$20 co-pay/outpatient visit; No charge for inpatient facility	Deductible and 20% co-insurance + balance billing	
	Skilled nursing care	No charge	Not covered	Up to 60 days per calendar year.
	Durable medical equipment	20% co-insurance	Deductible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits.
	Hospice service	No charge	Deductible and 20% co-insurance + balance billing	Failure to precertify may result in a reduction or no benefits. Up to 210 days per lifetime.
If your child needs dental or eye care	Eye exam	No charge	All balances over $20	One exam per calendar year.
	Glasses	No charge	All balances after $50	One pair of glasses per calendar year.
	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.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or Plan Document for 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)
- 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 **(This isn't a complete list. Check the Plan's SPD for other covered services and your costs for those services.)**

- Chiropractic care (Maximum 20 visits 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:

If you lose coverage under the Plan, then, depending upon the circumstances, Federal laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the Fund Office at 1-212-541-9880. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under the Plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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, (212) 541-9880. You may also contact any of the Fund's claims administrators at the address and phone numbers located on the back of your ID card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) located dol.gov/ebsa/healthreform.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-212-541-9880.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-212-541-9880.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-212-541-9880.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-212-541-9880.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this Plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different Plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this Plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,900
- **Patient pays** $640

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$30
Co-insurance	$460
Limits or exclusions	$150
Total	**$640**

Note: These numbers assume that the covered patient has given notice of her pregnancy to the Plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-212-541-9880.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,730
- **Patient pays** $670

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$320
Co-insurance	$270
Limits or exclusions	$80
Total	**$670**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or Health Plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this Plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers.** If the patient had received care from out-of-network **providers,** costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, co-payments,** and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your Health Plan allows.

Can I use Coverage Examples to compare Plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare Plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the Plan provides.

Are there other costs I should consider when comparing Plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium,** the more you'll pay in out-of-pocket costs, such as **co-payments, deductibles,** and **co-insurance.** You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.