




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, call the Fund Office at 1-973-589-5050. 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 1-973-589-5050 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	PPO <u>Providers</u> : \$250/individual or \$350/family Non-PPO <u>Providers</u> : \$500/individual or \$1,250/family <u>Deductible</u> applies for period 1/1 to 12/31 of each year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. PPO inpatient and same-day surgery facility, <u>prescription drugs</u> , hearing aid, and optical 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. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
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>?	Medical: PPO <u>Providers</u> : \$1,000/individual or \$2,000/family; Non-PPO <u>Providers</u> : \$5,000/individual or \$12,500/family. <u>Prescription drug</u> : \$8,450/individual or \$16,900/family. <u>Out-of-Pocket limit</u> applies for period 1/1 to 12/31 of each year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , optical, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/mymeritain/ or call the Aetna <u>Provider Line</u> at 1.800.343.3140 or the number on your ID card for a list of PPO <u>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>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	30% <u>coinsurance</u> plus <u>balance billing</u>	Chiropractic care maximum 12 visits per year. Acupuncture maximum \$500 per year. Chiropractic, acupuncture and physical therapy not covered simultaneously. Includes Telehealth Doctor/Physician visits. Benefits are payable for telehealth visits through the use of electronic information and communication technologies including a telephone, smartphone, tablet or computer with a web cam. Telehealth is a convenient and affordable option that allows you to talk to a doctor who can diagnose, recommend treatment and prescribe medication, when appropriate, for many common medical issues. It is not intended to replace your <u>primary care physician</u> but instead is designed to improve access to quality acute medical care at times when a physician's office is closed or does not have an available appointment time that works. Benefits are payable for telehealth visits with any physician who has the capabilities.
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	30% <u>coinsurance</u> plus <u>balance billing</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	30% <u>coinsurance</u> plus <u>balance billing</u>	

If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus <u>balance billing</u>	<u>Plan</u> only pays for tests necessary for diagnosis of any injury or sickness for which bona fide provisional diagnosis has been made because of existing symptoms. When required by law, non-PPO imaging and <u>diagnostic tests</u> will be treated as <u>in-network</u> .
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus <u>balance billing</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Select Generic drugs	Retail: \$4 <u>copay</u> /prescription (30-day supply); Mail Order: \$10 <u>copay</u> /prescription (90 day supply)	Retail only: \$4 <u>copay</u> /prescription (30-day supply) plus <u>balance billing</u>	If you fill a prescription at a non-participating pharmacy, the <u>Plan</u> will only reimburse the average wholesale prices (AWP) less 5% after the applicable <u>copay</u> . Mail order available for non-narcotic drugs only, <u>in-network</u> only. <u>No charge for FDA-approved generic (or brand name contraceptives if a generic is medically inappropriate) contraceptives and other ACA preventive medications. Over-the-counter drugs are only covered if required as ACA-preventive and if you have a prescription.</u>
	Generic drugs	Retail: \$15 <u>copay</u> /prescription (30-day supply); Mail Order: \$20 <u>copay</u> /prescription (90 day supply)	Retail only: \$15 <u>copay</u> /prescription (30-day supply) plus <u>balance billing</u>	
	Preferred brand drugs	Retail: \$25 <u>copay</u> /prescription (30-day supply); Mail Order: \$40 <u>copay</u> /prescription (90 day supply)	Retail only: \$25 <u>copay</u> /prescription (30-day supply) plus <u>balance billing</u>	
	Non-preferred brand drugs	Retail: \$40 <u>copay</u> /prescription (30-day supply); Mail Order: \$60 <u>copay</u> /prescription (90 day supply)	Retail only: \$40 <u>copay</u> /prescription (30-day supply) plus <u>balance billing</u>	
	<u>Specialty drugs</u>	Subject to above <u>copays</u>	Subject to above <u>copays</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> /visit; <u>Deductible</u> does not apply	30% <u>coinsurance</u> plus <u>balance billing</u>	Precertification is required. \$250 <u>copay</u> only applies once every 180 days. Maximum allowance for non-PPO facility is \$3,500.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	The maximum allowance: for non-PPO <u>provider</u> is \$2,000 per surgery; for anesthesia is 40% of surgical schedule; for assistant surgeon is 20% of surgical schedule; for multiple surgeries is 50% of surgical schedule for 2 nd -5 th surgeries and 25% for 6 th and additional surgeries. When required by law, non-PPO physician/surgeon fees will be treated as <u>in-network</u> .

If you need immediate medical attention	<u>Emergency room care</u>	\$75 <u>copay</u> /visit	\$75 <u>copay</u> /visit	<u>Copay</u> waived if admitted. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	Car service and non-emergency transport not covered. Air/sea emergency transportation only as <u>Medically Necessary</u> due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status. When required by law, non-PPO air ambulance services will be treated as <u>in-network</u> .
	<u>Urgent care</u>	\$25 <u>copay</u> /visit	30% <u>coinsurance</u> plus <u>balance billing</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /admission; <u>Deductible</u> does not apply	30% <u>coinsurance</u> plus <u>balance billing</u>	Precertification is required. \$250 <u>copay</u> only applies once every 180 days. Private room reimbursed at semi-private room rate.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	Precertification required. The maximum allowance: for non-PPO <u>provider</u> is 70% of Fund's fee schedule; for anesthesia is 40% of surgery schedule; for assistant surgeon is 20% of surgical schedule; for multiple surgeries is 50% of surgical schedule for 2 nd -5 th surgeries and 25% for 6 th and additional surgeries. When required by law, non-PPO physician/surgeon fees will be treated as <u>in-network</u> .

If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/Behavioral health: Office visit: \$25 <u>copay</u> /visit; Other outpatient facility: No charge, <u>Deductible</u> does not apply for outpatient facility Substance use disorder: Not covered	Mental/Behavioral health: 30% <u>coinsurance</u> plus <u>balance billing</u> Substance use disorder: Not covered	Mental/Behavioral health: Precertification is required for outpatient facilities. Substance use disorder: You must pay 100% of these expenses, even <u>in-network</u> .
	Inpatient services	Mental/Behavioral health: \$250 <u>copay</u> /admission; <u>Deductible</u> does not apply Substance use disorder: Not covered	Mental/Behavioral health: 30% <u>coinsurance</u> plus <u>balance billing</u> Substance use disorder: Not covered	Mental/Behavioral health: Precertification is required. \$250 <u>copay</u> only applies once every 180 days. Private room reimbursed at semi-private room rate. Substance use disorder: You must pay 100% of these expenses, even <u>in-network</u> .
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	The maximum allowance: for non-PPO <u>provider</u> is 70% of Fund's fee schedule; for anesthesia is 40% of surgery schedule; for assistant surgeon is 20% of surgical schedule; for multiple surgeries is 50% of surgical schedule for 2 nd -5 th surgeries and 25% for 6 th and additional surgeries. Cost sharing does not apply for preventive services. Depending on the type of services and <u>provider</u> , a <u>copay</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	
	Childbirth/delivery facility services	\$250 <u>copay</u> /admission; <u>Deductible</u> does not apply	30% <u>coinsurance</u> plus <u>balance billing</u>	

If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	Precertification required. Part-time, intermittent skilled nursing services and supplies. Home health aide not covered.
	<u>Rehabilitation services</u>	Inpatient: \$250 <u>copay</u> /admission; <u>Deductible</u> does not apply Outpatient: No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	Precertification required. Inpatient <u>PPO \$250 copay</u> only applies once every 180 days. Not covered simultaneously with chiropractic and/or acupuncture.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of these expenses, even <u>in-network</u> .
	<u>Skilled nursing care</u>	Skilled Nursing Facility (SNF): \$250 <u>copay</u> /admission; <u>Deductible</u> does not apply Outpatient: No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	Precertification required. Inpatient SNF charges only covered if, upon discharge from the hospital, warranted by medical condition; \$250 <u>copay</u> only applies once every 180 days.
	<u>Durable medical equipment</u>	No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	Precertification is required. Replacement only if <u>medically necessary</u> every 5 years.
	<u>Hospice services</u>	No charge	30% <u>coinsurance</u> plus <u>balance billing</u>	Precertification required. Must be Medicare-certified freestanding facility, unit of hospital or a Hospice agency.
If your child needs dental or eye care	Children's eye exam	No charge; <u>Deductible</u> does not apply.	Balances over Fund's fee schedule of \$50/exam	Optical benefits may be declined; do not accumulate toward the <u>Out-of-Pocket limit</u> . Payable up to <u>Plan's</u> fee schedule. Responsible for amount over Fund's allowance. One pair of glasses or contacts once every two years.
	Children's glasses	No charge up to Fund allowance; <u>Deductible</u> does not apply.	Balances over Fund's fee schedule of \$100/pair of glasses or contacts	
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even <u>in-network</u> .

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.)

- Cosmetic surgery
- Dental care (Adult and Child)
- Habilitation services
- Long-term care
- Private-duty nursing
- Substance use disorder outpatient and inpatient services
- Weight loss programs (except as required by the health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (up to \$500 per year; not covered simultaneously with chiropractic care or physical therapy)
- Bariatric surgery
- Chiropractic care (up to 12 visits per year; not covered simultaneously with acupuncture or physical therapy)
- Hearing aids (Up to \$1,500 every 3 years for the cost of each hearing aid (right and left))
- Infertility treatment (up to \$1,000 per lifetime)
- Non-emergency care when traveling outside the U.S. (payable as non-PPO (out-of-network) at applicable exchange rate)
- Routine eye care (Adult) (up to \$50 for routine eye exam and \$100 for frames/lenses totaling \$150 per person every two years)
- Routine foot care

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Heavy and General Laborers' Local Union 472 and Local Union 172 of New Jersey Welfare Fund, 700 Raymond Boulevard, Newark, NJ 07105; Phone: 973-589-5050; Fax: 973-589-1180. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact New Jersey State Insurance Department Office of Consumer Protection Services, NJ Department of Banking and Insurance, P.O. Box 329, Trenton, NJ 08625-0329; (609) 292-7272; Consumer Hotline: (800) 446-7467; <http://www.state.nj.us/dobi/consumer.htm>.

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 the 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 (Español): Para obtener asistencia en Español, llame al 973-589-5050.

—————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 \$250
- Specialist Copayment \$25
- Hospital (facility) Copayment \$250
- Other Coinsurance 10%

This EXAMPLE event includes services like:

- Specialist office visits
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$260
<u>Coinsurance</u>	\$110
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$680

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$250
- Specialist Copayment \$25
- Hospital (facility) Copayment \$250
- Other Coinsurance 10%

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
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$660
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$910

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$250
- Specialist Copayment \$25
- ER Copayment \$75
- Other Coinsurance 10%

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
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$180
<u>Coinsurance</u>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is-	\$440