




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, 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](http://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> ?	\$0 However, Medicare has a <u>deductible</u> which this <u>Plan</u> reimburses.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not applicable.	This <u>plan</u> does not have a <u>deductible</u> .
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.medicare.gov">www.medicare.gov</a> for a list of Medicare <u>network providers</u> . See <a href="http://www.aetna.com/docfind/custom/mymeritain/">www.aetna.com/docfind/custom/mymeritain/</a> 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</u> charge 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge	Amounts over Medicare allowance	<p><u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, <u>Plan</u> only pays 20% of Medicare approved amount. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges). Facility fee not covered after you reach Medicare lifetime limit. Follow Medicare Guidelines up to <u>Plan</u> limitations.</p>
	<u>Specialist</u> visit	No charge	Amounts over Medicare allowance	
	<u>Preventive care/screening/immunization</u>	No charge	Amounts over Medicare allowance	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Amounts over Medicare allowance	<p><u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, <u>Plan</u> only pays 20% of Medicare approved amount. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges). Facility fee not covered after you reach Medicare lifetime limit. Follow Medicare Guidelines up to <u>Plan</u> limitations.</p>
	Imaging (CT/PET scans, MRIs)	No charge	Amounts over Medicare allowance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <b><u>www.express-scripts.com</u></b></p>	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>	<p>Benefits provided through Express Scripts Medicare™ PDP. Prior authorization required from ESI for certain drugs. Step-therapy or other drug utilization management may apply.</p> <p>In order to be enrolled ESI Medicare PDP, you must be enrolled in Medicare Parts A and B. If you are not enrolled in Medicare Part A and B, you will not be eligible for the Medicare PDP.</p> <p>Please refer to the important material you receive from this Plan as well as ESI regarding your <u>prescription drug</u> benefits including any exclusions and limitations.</p>
	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> (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>	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	No charge	Amounts over Medicare allowance	<p><u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, <u>Plan</u> only pays 20% of Medicare approved amount. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges). Facility fee not covered after you reach Medicare lifetime limit. Follow Medicare Guidelines up to <u>Plan</u> limitations.</p>
	Physician/surgeon fees	No charge	Amounts over Medicare allowance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	No charge	Amounts over Medicare allowance	<u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, <u>Plan</u> only pays 20% of Medicare approved amount. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges). Facility fee not covered after you reach Medicare lifetime limit. Follow Medicare Guidelines up to <u>Plan</u> limitations.
	<u>Emergency medical transportation</u>	No charge	Amounts over Medicare allowance	
	<u>Urgent care</u>	No charge	Amounts over Medicare allowance	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	Amounts over Medicare allowance	<u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, <u>Plan</u> only pays 20% of Medicare approved amount. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges). Facility fee not covered after you reach Medicare lifetime limit. Follow Medicare Guidelines up to <u>Plan</u> limitations.
	Physician/surgeon fees	No charge	Amounts over Medicare allowance	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	Amounts over Medicare allowance	<u>Plan</u> pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, <u>Plan</u> only pays 20% of Medicare approved amount. <u>Plan</u> does not cover <u>providers</u> who have opted out of Medicare (you pay 100% of these charges). Facility fee not covered after you reach Medicare lifetime limit. Follow Medicare Guidelines up to <u>Plan</u> limitations.
	Inpatient services	No charge	Amounts over Medicare allowance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	Amounts over Medicare allowance	Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, Plan only pays 20% of Medicare approved amount. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). Facility fee not covered after you reach Medicare lifetime limit. Follow Medicare Guidelines up to Plan limitations. Dependent children not covered for maternity service.
	Childbirth/delivery professional services	No charge	Amounts over Medicare allowance	
	Childbirth/delivery facility services	No charge	Amounts over Medicare allowance	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Amounts over Medicare allowance	Plan pays second to Medicare based on the Medicare approved amount. If you are not enrolled in Medicare, Plan only pays 20% of Medicare approved amount. Plan does not cover providers who have opted out of Medicare (you pay 100% of these charges). Facility fee not covered after you reach Medicare lifetime limit. Follow Medicare Guidelines up to Plan limitations. Part-time, intermittent skilled nursing services and supplies. Home Health Aides are not covered.
	<u>Rehabilitation services</u>	No charge	Amounts over Medicare allowance	
	<u>Habilitation services</u>	No charge	Amounts over Medicare allowance	
	<u>Skilled nursing care</u>	No charge	Amounts over Medicare allowance	
	<u>Durable medical equipment</u>	No charge	Amounts over Medicare allowance	
	<u>Hospice services</u>	No charge	Amounts over Medicare allowance	
If your child needs dental or eye care	Children's eye exam	No charge	Balances over Fund's fee schedule of \$50/exam	Payable up to Plan's fee schedule. Optical benefits may be declined.
	Children's glasses	No charge up to Fund allowance	Balances over Fund's fee schedule of \$100/pair of glasses or contacts	One pair of glasses or contacts once every two years. Responsible for amount over Fund's allowance. Optical benefits may be declined.
	Children's dental check-up	No charge	Balances over Fund's fee schedule	Dental check-up once every 6 months. Dental benefits may be declined.

## 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
- Infertility treatment
- Long-term care
- Medical Expenses Not Covered by Medicare
- Private-duty nursing
- Weight loss programs

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

- Acupuncture (to the extent Medicare covers such services this Plan will pay benefits up to the Medicare allowance up to \$500 per year; not covered simultaneously with chiropractic care or physical therapy)
- Bariatric surgery (to extent Medicare covers such services, this Plan will pay benefits up to Medicare allowance)
- Chiropractic care (to extent Medicare covers such services, this Plan will pay benefits up to Medicare allowance; not covered simultaneously with acupuncture or physical therapy)
- Dental care (Adult) (\$3,250 per family per year)
- Hearing aids (Up to \$1,500 every 3 years for the cost of each hearing aid (right and left))
- Non-emergency care when traveling outside the U.S. (payable at 20% of the Funds fee schedule; claim at applicable exchange rate)
- Routine eye care (Adult) (up to \$150 per person every 2 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](http://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](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: 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](http://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? **No**

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 \$0
- Specialist Copayment \$0
- Hospital (facility) Copayment \$0
- Other Coinsurance None

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$70</b>

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

- The plan's overall deductible \$0
- Specialist Copayment \$0
- Hospital (facility) Copayment \$0
- Other Coinsurance None

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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$410
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$160
<b>The total Joe would pay is</b>	<b>\$570</b>

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

- The plan's overall deductible \$0
- Specialist Copayment \$0
- Hospital (facility) Copayment \$0
- Other Coinsurance None

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