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.healthcare.gov/sbc-glossary/ or call 1-973-589-5050 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO Providers: $250/individual or $350/family Deductible applies for period 1/1 to 12/31 of each year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and PPO inpatient and same-day surgery facility, prescription drugs, hearing aid and optical services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance 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 deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: PPO Providers: $1,000/individual or $2,000/family. Prescription drug: $1,000/individual or $2,000/family. Out-of-Pocket limit applies for period 1/1 to 12/31 of each year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, penalties for failure to obtain preauthorization, optical and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain/ or call the Aetna Provider Line at 1.800.343.3140 or the number on your ID card for a list of PPO providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the full cost if you use an out-of-network provider. Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	Not covered	Chiropractic maximum 12 visits per year. Acupuncture maximum $500 per year. Chiropractic, acupuncture and physical therapy not covered simultaneously.
	Specialist visit	$30 copay/visit	Not covered	
	Preventive care/screening/ immunization	No charge Deductible does not apply	Not covered	Age and frequency limits apply. Adult physical covered once per year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	Plan 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 diagnostic tests will be treated as in-network.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**	Select Generic drugs	Retail: $4 copay/prescription (30-day supply); Mail Order: $10 copay/prescription (90 day supply)	Retail only: $4 copay/prescription (30-day supply) plus balance billing	If you fill a prescription at a non-participating pharmacy, the Plan will only reimburse the average wholesale price (AWP) less 5% after the applicable copay. Mail order available for non-narcotic drugs only, in-network only. 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.
	Generic drugs	Retail: $15 copay/prescription (30-day supply); Mail Order: $20 copay/prescription (90 day supply)	Retail only: $15 copay/prescription (30-day supply) plus balance billing	
	Preferred brand drugs	Retail: $25 copay/prescription (30-day supply); Mail Order: $40 copay (90 day supply)	Retail only: $25 copay/prescription (30-day supply) plus balance billing	
	Non-preferred brand drugs	Retail: $40 copay/prescription (30-day supply); Mail Order: $60 copay/prescription (90 day supply)	Retail only: $40 copay/prescription (30-day supply) plus balance billing	
	Specialty drugs	Subject to above copays	Subject to above copays	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after $250 copay; Deductible does not apply	Not covered	Precertification is required. $250 copay only applies once every 180 days.
	Physician/surgeon fees	No charge	Not covered	When required by law, non-PPO physician/surgeon fees will be treated as in-network.
If you need immediate medical attention	Emergency room care	$75 copay/visit	$75 copay/visit	Copay waived if admitted. Professional/physician charges may be billed separately.
	Emergency medical transportation	No charge	Not covered	Car service and non-emergency transport not covered. Air/sea emergency transportation only as Medically Necessary 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 in-network.
	Urgent care	$30 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/visit; Deductible does not apply	Not covered	Precertification is required. $250 copay only applies once every 180 days. Private room reimbursed at semi-private room rate.
	Physician/surgeon fees	No charge	Not covered	When required by law, non-PPO physician/surgeon fees will be treated as in-network.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/behavioral health: Office visit: $30 copay/visit; Other outpatient facility: No charge, Deductible does not apply to other outpatient facility Substance use disorder: Not covered	Not covered	Precertification is required for outpatient facilities for Mental/Behavioral health. You must pay 100% of these expenses, even in-network for Substance use disorder.
	Inpatient services	Mental/Behavioral health: $250 copay/admission; Deductible does not apply Substance use disorder: Not covered	Not covered	Precertification is required. $250 copay only applies once every 180 days for Mental/Behavioral health. Private room reimbursed at semi-private room rate. You must pay 100% of these expenses, even in-network for Substance use disorder.
If you are pregnant	Office visits	No charge	Not covered	Prenatal care (other than ACA-required preventive screenings) and delivery expenses are not covered for dependent children. Cost sharing does not apply for preventive services. Depending on the type of services and provider, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250 copay/admission; Deductible does not apply	Not covered	Delivery expenses are not covered for dependent children. $250 copay only applies once every 180 days. Private room reimbursed at semi-private room rate. Precertification required for stays that exceed will exceed 48 hours (for normal delivery) or 96 hours (for C-section).

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 need help recovering or have other special health needs	Home health care	No charge	Not covered	Precertification required. Part-time, intermittent skilled nursing services and supplies. Home health aide not covered.
	Rehabilitation services	Inpatient: $250 copay/admission; Outpatient: no charge	Not covered	Precertification required. Not covered simultaneously with chiropractic and/or acupuncture.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	Skilled Nursing Facility (SNF): $250 copay/admission; Deductible does not apply Outpatient: No charge	Not covered	Precertification required. Inpatient SNF charges only covered if, upon discharge from the hospital, warranted by medical condition; $250 copay only applies once every 180 days.
	Durable medical equipment	No charge	Not covered	Precertification is required. Replacement only if medically necessary every 5 years.
	Hospice services	No charge	Not covered	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; Deductible does not apply	Balances over Fund's fee schedule of $50/exam	Payable up to Plan's fee schedule. Optical benefits may be declined; do not accumulate toward the Out-of-Pocket limit.
	Children's glasses	No charge up to Fund allowance; Deductible does not apply	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; do not accumulate toward the Out-of-Pocket limit.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even in-network.

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 inpatient and outpatient 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 ($10,000 maximum per calendar year, combined medical and Rx)
- 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** **$30**
- **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$260
Coinsurance	$110
What isn't covered	
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** **$30**
- **Hospital (facility) Copayment** **$250**
- **Other Coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$650
Coinsurance	$0
What isn't covered	
Limits or exclusions	$160
The total Joe would pay is	**$1,060**

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

- **The plan's overall deductible** **$250**
- **Specialist Copayment** **$30**
- **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$460**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.