



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 <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 deductible?	Yes. <u>Preventive care</u> and PPO inpatient and same-day surgery facility, <u>prescription drugs</u> , optical and dental 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 <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	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> : \$1,000/individual or \$2,000/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 out-of-pocket limit?	<u>Premiums</u> , <u>balance billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , optical, dental 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 network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain/ or call the Aetna <u>Provider</u> Line 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 referral to see a specialist?	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)	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 <u>copay</u> /visit	40% <u>coinsurance</u> plus <u>balance billing</u>	Chiropractic maximum 12 visits per year. Acupuncture maximum \$500 per covered person per year. Chiropractic, acupuncture and physical therapy not covered simultaneously.
	Specialist visit	\$30 <u>copay</u> /visit	40% <u>coinsurance</u> plus <u>balance billing</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	40% <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>	40% <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>	40% <u>coinsurance</u> plus <u>balance billing</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non PPO Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.express-scripts.com</u>	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 actual wholesale prices (AWP) less 5% after the applicable <u>copay</u> . Mail order available for non-narcotic drugs only, <u>in-network</u> 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 <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>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> /admission; <u>Deductible</u> does not apply	40% <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 per stay.
	Physician/surgeon fees	No charge	40% <u>coinsurance</u> plus <u>balance billing</u>	The maximum allowance: for non-PPO <u>provider</u> is 60% of Funds fee schedule; for anesthesia is 40% of surgery schedule; for assistant surgeon is 20% of surgical schedule; for multiple surgeries is 50% for 2 nd to 5 th surgeries and 25% for 6 th and additional surgeries of the surgical schedule. When required by law, non-PPO physician/surgeon fees will be treated as <u>in-network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non PPO Provider (You will pay the most)	
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	40% <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>	\$30 <u>copay</u> /visit	40% <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	40% <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	40% <u>coinsurance</u> plus <u>balance billing</u>	The maximum allowance: for non-PPO <u>provider</u> ; for anesthesia is 40% of surgery schedule; for assistant surgeon is 20% of surgical schedule; for multiple surgeries is 50% for 2 nd -5 th surgeries and 25% for 6 th and additional surgeries of the surgical schedule. When required by law, non-PPO physician/surgeon fees will be treated as <u>in-network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network 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	Office visit: \$30 <u>copay</u> /visit, after <u>deductible</u> ; Other outpatient facility: No charge; <u>Deductible</u> does not apply	40% <u>coinsurance</u> plus <u>balance billing</u>	Precertification is required for outpatient facilities.
	Inpatient services	\$250 <u>copay</u> /admission; <u>Deductible</u> does not apply	40% <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.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u> plus <u>balance billing</u>	The maximum allowance: for non-PPO <u>provider</u> is 60% of Funds fee schedule; for anesthesia is 40% of surgery schedule; for assistant surgeon is 20% of surgical schedule; for multiple surgeries is 50% for 2 nd -5 th surgeries and 25% for 6 th and additional surgeries of the surgical schedule. Cost sharing does not apply for preventive services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of services and <u>provider</u> , a <u>copay</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Prenatal care (other than ACA-required preventive screenings) and delivery expenses are not covered for dependent children.
	Childbirth/delivery professional services	No charge	40% <u>coinsurance</u> plus <u>balance billing</u>	
	Childbirth/delivery facility services	\$250 <u>copay</u> /admission; <u>Deductible</u> does not apply	40% <u>coinsurance</u> plus <u>balance billing</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network 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	<u>Home health care</u>	No charge	40% <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/admission</u> ; <u>Deductible</u> does not apply Outpatient: No charge	40% <u>coinsurance</u> plus <u>balance billing</u>	Precertification required. 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/admission</u> ; <u>Deductible</u> does not apply Outpatient: No charge	40% <u>coinsurance</u> plus <u>balance billing</u>	Precertification required. Inpatient SNF charges 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	40% <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	40% <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.
	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	Responsible for amount over Fund's allowance. One pair of glasses or contacts once every two years.
	Children's dental check-up	No charge; <u>Deductible</u> does not apply	No charge up to Fund's fee schedule	Once every 6 months. Dental benefits may be declined; do not accumulate toward the <u>Out-of-Pocket limit</u> .

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none">• Cosmetic surgery• <u>Habilitation services</u>	<ul style="list-style-type: none">• Long-term care	<ul style="list-style-type: none">• Private-duty nursing• 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 <u>plan</u> document.)		
<ul style="list-style-type: none">• 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)	<ul style="list-style-type: none">• Dental care (Adult) (up to \$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))• Infertility treatment (\$10,000 maximum per calendar year, combined medical and Rx)	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S. (payable as non-PPO (<u>out-of-network</u>) 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 <u>plan's overall deductible</u>	\$250
■ <u>Specialist Copayment</u>	\$30
■ <u>Hospital (facility) Copayment</u>	\$250
■ <u>Other Coinsurance</u>	10%

This **EXAMPLE** event includes services like:

Specialist office visits (*excluding prenatal care 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:

<i>Cost Sharing</i>	
<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 <u>plan's overall deductible</u>	\$250
■ <u>Specialist Copayment</u>	\$30
■ <u>Hospital (facility) Copayment</u>	\$250
■ <u>Other Coinsurance</u>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$650
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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 <u>plan's overall deductible</u>	\$250
■ <u>Specialist Copayment</u>	\$30
■ <u>ER Copayment</u>	\$75
■ <u>Other Coinsurance</u>	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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$10
<i>What isn't covered</i>	
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.