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, contact the Fund office. 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 receive a copy of the Glossary by calling the Welfare Fund office at: 908-688-0723 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150**/Individual or **$300**/family	Generally, you must pay 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.	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 your SPD for details.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. This plan has no out-of-pocket-limit.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.	This plan has no out-of-pocket-limit.
Will you pay less if you use a network provider?	Yes. See your ID card for information on network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay all costs if you use an out-of-network provider. This plan does not cover out-of-network services.
Do you need a referral to see a specialist?	No.	This plan will pay some or all of the costs to see a specialist for covered services.

Questions: Call (908) 688-0723. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can request a copy by calling (908) 688-0723.

All copayment and coinsurance costs shown in this chart are applied after your deductible has been met, unless stated otherwise.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	Not covered	Clinic visits are not covered.
	Specialist visit	$20 copay/visit	Not covered	Clinic visits are not covered.
	Preventive care/screening/ immunization	No charge	Not covered	Limited to 1 visit per year.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay	Not covered	$10 Copay for blood work only. Deductible does not apply.
	Imaging (CT/PET scans, MRIs)	$50 copay	Not covered	Pre-certification required. $50 Copay waived if you use a OneCall provider.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available in your SPD.	Generic drugs	Greater of $5 copay or 20% coinsurance	Paid according to Plan rules.	Covers up to 30-day supply retail. 90-day supply at retail maximum. 90-day equals the greater of 2 copays or 20% coinsurance. Maximum $10,000 per person. After $10,000, Plan pays 60%.
	Preferred brand drugs	Greater of $15 copay or 20% coinsurance	Paid according to Plan rules.	
	Non-preferred brand drugs	Greater of $30 copay or 20% coinsurance	Paid according to Plan rules.	
	Specialty drugs	If enrolled in Payer Matrix, $0 copay. If not enrolled in Payer Matrix, not covered.	Not covered	Specialty drugs are available through Payer Matrix who will assist you in obtaining financial assistance to get your specialty drugs. You must enroll with Payer Matrix to obtain this assistance. If you do not enroll, you will have to pay the full cost of the drug. Prescriptions must comply with the Plan's specialty drug list.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copay	Not covered	Pre-certification required.
	Physician/surgeon fees	$0 copay	Not covered	None.
If you need immediate medical attention	Emergency room care	$100 copay	Not covered	Out-of-network emergency care may be appealed. Deductible does not apply.
	Emergency medical transportation	$0 copay	20% coinsurance	Up to reasonable and customary. No air ambulance.
	Urgent care	$0 copay	Not covered	None.

[* For more information about limitations and exceptions, see the SPD.]

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 have a hospital stay	Facility fee (e.g., hospital room)	$0 copay	Not covered	120 days maximum. 30 days paid at 100%; next 90 days paid at 60% of allowable charge. Pre-certification required.
	Physician/surgeon fees	$0 copay	Not covered	Pre-certification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay	Not covered	Substance abuse is not covered.
	Inpatient services	$0 copay	Not covered	Substance abuse is not covered. Pre-certification required. Limited to 120 days. 30 days paid at 100%, next 90 days paid at 60% of allowable charges.
If you are pregnant	Office visits	$0 copay	Not covered	None.
	Childbirth/delivery professional services	$0 copay	Not covered	Pre-certification is required.
	Childbirth/delivery facility services	$0 copay	Not covered	Limited to 120 days. 30 days paid at 100%, next 90 days paid at 60% of allowable charges. Pre-certification is required.
If you need help recovering or have other special health needs	Home health care	$0 copay	Not covered	Limited to 40 visit annual maximum. Pre-certification required.
	Rehabilitation services	$0 copay	Not covered	Limited to 20 visit annual maximum. Pre-certification required.
	Habilitation services	$0 copay	Not covered	Limited to 20 visit annual maximum. Pre-certification required.
	Skilled nursing care	$0 copay	Not covered	Limited to 10-day maximum. Pre-certification required.
	Durable medical equipment	0%/20% coinsurance	Not covered	Rental fee up to purchase price. $500 paid at 100%; thereafter 20% coinsurance. Pre-certification required. Deductible does not apply.
	Hospice services	$0 copay	Not covered	30-day maximum respite care at home; 5-day maximum inpatient. Pre-certification required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	In-network only up to Plan maximum.
	Children's glasses	No charge	Not covered	In-network only up to Plan maximum.
	Children's dental check-up	No charge	Not covered	In-network only up to Plan maximum.

[* For more information about limitations and exceptions, see the SPD.]

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.)

- Cochlear implants
- Cosmetic surgery
- Infertility treatment
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Transplants
- Routine foot care
- Substance Abuse
- Weight loss programs
- Hearing aids

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

- Vision
- Preventive Care
- Orthotics
- Dental Plan
- Chiropractic Care
- Sleep Studies
- Dialysis
- Radiation Therapy

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You can call the plan at: 908-688-0723. You may also contact the Department of Labor's Employee Benefits Security Administration at: 1-866-444-EBSA 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 SPD provides complete information 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 the Welfare Fund at 908-688-0723.

Does this plan provide Minimum Essential Coverage? [Yes]

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 516-741-5564.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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

[* For more information about limitations and exceptions, see the SPD.]

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** **$150**
- **Specialist *[cost sharing]*** **$20**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

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*)

Total Example Cost	**$7,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$210**

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

- **The plan's overall deductible** **$150**
- **Specialist *[cost sharing]*** **$20**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **20%**

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	**$4,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$490
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$840**

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

- **The plan's overall deductible** **$150**
- **Specialist *[cost sharing]*** **$20**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

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	**$3,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$210**

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