
 This 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, go to [www.825funds.org](http://www.825funds.org) or call 1-973-671-6800. 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.com](http://www.dol.gov/ebsa/healthreform.com) or call 1-973-671-6800 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	PPO: \$0 Non-PPO: \$200/individual; \$600/family.	PPO: See the Common Medical Events Chart below for your costs for services this <u>plan</u> covers. Non-PPO: 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	PPO: Not Applicable Non-PPO: Yes. Facility charges, mental health/substance abuse services, <u>emergency services</u> /transport, <u>skilled nursing care</u> and vision are covered before you meet your <u>deductible</u> .	PPO: This <u>plan</u> does not have a <u>deductible</u> for <u>in-network</u> services. Non-PPO: 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.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	PPO: \$5,100/individual; \$10,200/family Non-PPO: No limit. <u>Prescription Drugs</u> : \$4,000/individual; \$8,000/family	PPO: The <u>out-of-pocket limit</u> is the most you could pay in a year for in-network covered services. Non-PPO: This <u>plan</u> does not have an out-of-network <u>out-of-pocket limit</u> on your expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	PPO: <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> and health care this <u>plan</u> doesn't cover. Non-PPO: Not applicable.	PPO: Even though you pay these expenses, they don't count toward the in-network <u>out-of-pocket limit</u> . Non-PPO: This <u>plan</u> does not have an out-of-network <u>out-of-pocket limit</u> on your expenses.
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. Visit: <a href="http://HorizonBlue.com/doctorfinder">HorizonBlue.com/doctorfinder</a> or call 1-800-810-2583 to locate <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 a non-PPO <u>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 PPO <u>provider</u> might use a non-PPO <u>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 permission from this <u>plan</u> .
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 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit, then 20% <u>coinsurance</u> , plus <u>balance billing</u>	None.
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit, then 20% <u>coinsurance</u> , plus <u>balance billing</u>	Chiropractic covered services include X-rays, manipulation and subluxation of spine only; maximum 52 visits/person per calendar year.
	<u>Preventive care/screening/immunization</u>	No charge	\$15 <u>copay</u> /visit; \$25 <u>copay</u> /diagnostic, then 20% <u>coinsurance</u> , plus <u>balance billing</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	X-ray: \$25 <u>copay</u> /x-ray Laboratory: \$10 <u>copay</u> /test	X-ray: \$25 <u>copay</u> /x-ray Laboratory: \$10 <u>copay</u> /test, then 20% <u>coinsurance</u> , plus <u>balance billing</u>	Coverage for genetic testing limited to amniocentesis, BRCA1 and BRCA2, Oncotype DX breast cancer assay, and cystic fibrosis carrier screening. Only one \$25 <u>copay</u> and one \$10 <u>copay</u> apply daily.
	Imaging (CT/PET scans, MRIs)	\$25 <u>copay</u> /test	\$25 <u>copay</u> /test, then 20% <u>coinsurance</u> , plus <u>balance billing</u>	Requires prior authorization. Only one <u>copay</u> applies daily.
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	Not covered	Not covered	No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).  Except for ACA-required contraceptive coverage and chemotherapy medications, you must pay 100% of these expenses, even <u>in-network</u> .
	Preferred brand drugs			
	Non-preferred brand drugs			
	<u>Specialty drugs</u>			

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Facility fee: \$25 <u>copay</u> /incident	Outpatient hospital facility fee: \$25 <u>copay</u> /incident; <u>deductible</u> does not apply. Ambulatory surgical center: Not covered	Precertification is required. <u>Out-of-network</u> ambulatory surgical centers are not covered.
	Physician/surgeon fees	When surgical fee is greater than \$100: \$25 <u>copay</u> /surgical encounter; When surgical fee is \$100 or less: \$10 <u>copay</u> /surgical encounter	When surgical fee is greater than \$100: \$25 <u>copay</u> /surgical encounter; When surgical fee is \$100 or less: \$10 <u>copay</u> /surgical encounter, then 20% <u>coinsurance</u> , plus <u>balance billing</u>	Precertification is required. If more than one operation in same field or through one incision, the maximum benefit is amount payable for the primary surgery. If operations in different fields with separate incisions, maximum benefit is 100% for the primary surgery and 50% for the second & subsequent procedures.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$25 <u>copay</u> /incident (facility)	\$25 <u>copay</u> /incident (facility); <u>deductible</u> does not apply	Precertification for emergency treatment required within 2 days following treatment.
	<u>Emergency medical transportation</u>	Basic Life Support: Balances over \$700/trip Advanced Life Support: Balances over \$1,000/trip	Basic Life Support: Balances over \$700/trip Advanced Life Support: Balances over \$1,000/trip; <u>deductible</u> does not apply	Coverage limited to \$700 <u>Plan Allowance</u> /trip (Basic Life Support) and \$1,000 <u>Plan Allowance</u> /trip (Advanced Life Support).
	<u>Urgent care</u>	No charge (physician care)	No charge (physician care)	<u>Provider's</u> specialty must be emergency care and services must be billed with codes denoting <u>emergency services</u> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$25 <u>copay</u> /confinement	\$500 <u>copay</u> /confinement, then 30% <u>coinsurance</u> , plus <u>balance billing</u> ; <u>deductible</u> does not apply	Limited to 365 days per illness/injury. Precertification required.
	Physician/surgeon fees	Physician: \$15 <u>copay</u> /visit; Surgeon: \$25/surgical encounter	\$15 <u>copay</u> /visit; \$25 <u>copay</u> /surgical encounter, then 20% <u>coinsurance</u> , plus <u>balance billing</u> .	If more than one operation in same field or through one incision, maximum benefit is amount payable for primary surgery. If operations in different fields with separate incisions, maximum benefit is 100% for the primary surgery and 50% for the second & subsequent procedures.

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Facility: \$15 <u>copay</u> /treatment plan Physician: \$15 <u>copay</u> /visit	Facility: \$15 <u>copay</u> /treatment plan; <u>deductible</u> does not apply Physician: \$15 <u>copay</u> /visit, then 20% <u>coinsurance</u> , plus <u>balance billing</u> ; <u>deductible</u> does not apply	Precertification is required for all inpatient admissions, partial <u>hospitalizations</u> and intensive outpatient treatment.
	Inpatient services	Facility: \$25 <u>copay</u> /confinement Physician visits: No charge	Facility: \$500/confinement, then 30% <u>coinsurance</u> , plus <u>balance billing</u> ; <u>deductible</u> does not apply Physician visits: 20% <u>coinsurance</u> , plus <u>balance billing</u> ; <u>deductible</u> does not apply	Precertification is required for all inpatient admissions, partial <u>hospitalizations</u> and intensive outpatient treatment.
<b>If you are pregnant</b>	Office visits	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit, then 20% <u>coinsurance</u> , plus <u>balance billing</u> .	Limited to a member and legal spouse of a member provided delivery occurs while considered an eligible participant of the <u>Plan</u> . Maternity services not covered for dependent children. Prenatal care (other than ACA-required preventive <u>screenings</u> ) is not covered for dependent children. Delivery expenses are not covered for dependent children. <u>Plan</u> considers 50% of fee of obstetrician for certified mid-wife. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$25 <u>copay</u> /delivery	\$25 <u>copay</u> , then 20% <u>coinsurance</u> , plus <u>balance billing</u> .	
	Childbirth/delivery facility services	\$25 <u>copay</u> /facility charge	\$500 <u>copay</u> /confinement, then 30% <u>coinsurance</u> , plus <u>balance billing</u> ; <u>deductible</u> does not apply	

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	20% <u>coinsurance</u> , plus <u>balance billing</u> .	Precertification required. Custodial care not covered.
	<u>Rehabilitation services</u>	Speech: \$15 <u>copay</u> /visit for visits 1-24; \$25 <u>copay</u> /visit thereafter; Physical Therapy and Cardiac Rehab: \$15 <u>copay</u> for initial eval. and reeval.	Speech: \$15 <u>copay</u> /visit for visits 1-24; \$25 <u>copay</u> /visit thereafter; Physical Therapy and Cardiac Rehab: \$15 <u>copay</u> for initial eval. and reeval., then 20% <u>coinsurance</u> , plus <u>balance billing</u> .	Requires prior authorization. Physical therapy: Must be prescribed by a M.D. or D.O. & rendered by a physician or licensed physical therapist under the orders of a physician.
	<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>	\$25 <u>copay</u> /confinement	\$500 <u>copay</u> /confinement, then 30% <u>coinsurance</u> , plus <u>balance billing</u> ; <u>deductible</u> does not apply	Precertification required. Subacute care must start within 7 days after stay of at least 5 consecutive days in hospital. Limited to 100 days per condition.
	<u>Durable medical equipment</u>	No charge	20% <u>coinsurance</u> , plus <u>balance billing</u> .	Precertification required. Must be <u>medically necessary</u> .
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u> , plus <u>balance billing</u> .	Precertification required. Limited to the terminally ill.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 <u>copay</u> /exam	Balances over \$40 allowance; <u>deductible</u> does not apply	For patients age 19 & over: - Exams limited to once per calendar year - Lenses (pair) limited to once per calendar year - Frames limited to once every other calendar year
	Children's glasses	\$25 <u>copay</u> /lenses	Lenses: Balances over allowances Frames: Balances over \$50 allowance <u>Deductible</u> does not apply	
	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
- Prescription Drugs
- Non-emergency care when traveling outside the U.S.

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

- Acupuncture (Precertification required; except when used as substitute for anesthesia, benefits subject to \$6,000/calendar year maximum)
- Bariatric surgery (Precertification required; covered for morbid obesity)
- Chiropractic care (Maximum 52 visits/calendar year by a licensed chiropractor -including X-rays)
- Hearing aids (Limited to \$1,500/aid)
- Infertility treatment (Precertification required; except for artificial insemination and standard dosages, lengths of treatment and cycles of therapy of prescription drugs, treatment limited to \$2,000 per 12-month period)
- Private-duty nursing (Precertification required; must be rendered by non-relative)
- Routine eye care (Adult)(covered up to scheduled allowance; for adults, exams and lenses limited to once/calendar year and frames limited to once/every other calendar year)
- Routine foot care (Maximum \$750 per calendar year)
- Weight loss programs (Precertification required; covered for morbid obesity)

**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 these agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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: the Fund Office at Operating Engineers Local 825 Fund Service Facilities, 65 Springfield Avenue, 2nd Floor, Springfield, NJ 07081 or via phone at 1-973-671-6800. 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).

### 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 1-973-671-6800.

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



**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.

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- The plan's overall deductible \$0
- Specialist co-pay \$15
- Hospital (facility) co-pay \$25
- Other co-pay \$25

**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:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$170
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$240</b>

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- The plan's overall deductible \$0
- Specialist co-pay \$15
- Hospital (facility) co-pay \$25
- Other co-pay \$25

**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:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$170
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,240
<b>The total Joe would pay is</b>	<b>\$4,410</b>

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- The plan's overall deductible \$0
- Specialist co-pay \$15
- Hospital (facility) co-pay \$25
- Other co-pay \$25

**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:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$440
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$450</b>