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 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/ebsa/healthreform.com or call 1-973-671-6800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO: $0 Non-PPO: $200/individual; $600/family.	PPO: See the Common Medical Events chart below for your costs for services this plan covers. Non-PPO: 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?	PPO: Not applicable Non-PPO: Yes. Prescription drugs, facility charges, mental health/substance abuse services, emergency services/transport, skilled nursing care, vision and dental are covered before you meet your deductible.	PPO: This plan does not have a deductible for in-network services. Non-PPO: This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
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?	PPO: $5,100/individual and $10,200/family Non-PPO: No limit. Prescription Drugs: $4,000/individual and $8,000/family	PPO and Prescription Drugs: The out-of-pocket limit is the most you could pay in a year for in-network covered services. Non-PPO: This plan does not have an out-of-network out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	PPO: Premiums, balance-billing charges, penalties for failure to obtain preauthorization and health care this plan doesn't cover. Non-PPO: Not applicable.	PPO: Even though you pay these expenses, they don't count toward the in-network out-of-pocket limit. Non-PPO: This plan does not have an out-of-network out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. Visit HorizonBlue.com/doctorfinder or call 1-800-810-2583 to locate providers.	The plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use a non-PPO provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your PPO provider might use a non-PPO 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 permission from this plan.

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	$15 copay/visit	$15 copay/visit, then 20% coinsurance, plus balance billing	None
	Specialist visit	$15 copay/visit	$15 copay/visit, then 20% coinsurance, plus balance billing	Chiropractic covered services include X-rays, manipulation and subluxation of spine only; maximum 52 visits/person per calendar year.
	Preventive care/screening/ immunization	No charge	$15 copay/visit; $25 copay/diagnostic, then 20% coinsurance, plus balance billing	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)	X-ray: $25 copay/x-ray Laboratory: $10 copay/test	X-ray: $25 copay/x-ray Laboratory: $10 copay/test, then 20% coinsurance, plus balance billing	Coverage for genetic testing limited to amniocentesis, BRCA1 and BRCA2, Oncotype DX breast cancer assay, and cystic fibrosis carrier screening. Only one $25 copay and one $10 copay apply daily.
	Imaging (CT/PET scans, MRIs)	$25 copay/test	$25 copay/test, then 20% coinsurance, plus balance billing	Requires prior authorization. Only one copay applies daily.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail: $7 copay/fill Mail Order: $14 copay/fill	Retail: $7 copay/fill plus balance billing. Deductible does not apply.	Retail: 30-day supply Mail Order: 90-day supply Non-PPO Pharmacy: Must pay and then submit for reimbursement. Reimbursed up to the network pharmacy amount, less copayment. You are responsible for balance billing. No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). Except for preventive items, over-the-counter items, even if prescribed by a physician, are not covered. Medicines to treat impotency, vitamins, minerals and herbs are not covered. Certain non-preferred drugs/Tier 4 (e.g., acne treatment, gastrointestinal disorder) subject to 50% coinsurance with $30 minimum at retail and 50% coinsurance with $60 minimum at mail order. No coverage for formulary exclusions.
	Preferred brand drugs	Retail: 20% coinsurance to $75 maximum copay/fill Mail Order: 20% coinsurance to $150 maximum copay/fill	Retail: 20% coinsurance to $75 maximum plus balance billing. Deductible does not apply.	
	Non-preferred brand drugs	Retail: 35% coinsurance to $75 maximum copay/fill Mail Order: 35% coinsurance to $150 maximum copay/fill	Retail: 35% coinsurance to $75 maximum plus balance billing. Deductible does not apply.	
	Specialty drugs	$50 copay per 30-day/fill	No coverage	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Facility fee: $25 copay/incident	Outpatient hospital facility fee: $25 copay/incident; deductible does not apply. Ambulatory surgical center: Not covered	Precertification is required. Out-of-network ambulatory surgical centers are not covered.
	Physician/surgeon fees	When surgical fee is greater than $100: $25 copay/surgical encounter; When surgical fee is $100 or less: $10 copay/surgical encounter	$25 or $10 copay/surgical encounter, then 20% coinsurance, plus balance billing	If more than one operation in same field or through one incision, the maximum benefit amount is 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.

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 immediate medical attention	Emergency room care	$25 copay/incident (facility)	$25 copay/incident (facility); deductible does not apply.	Precertification for emergency treatment required within 2 days following treatment.
	Emergency medical transportation	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; deductible does not apply	Coverage limited to $700 Plan Allowance/trip (Basic Life Support) and $1,000 Plan Allowance/trip (Advanced Life Support).
	Urgent care	No charge (physician care)	No charge (physician care)	Provider's specialty must be emergency care and services must be billed with codes denoting emergency services.
If you have a hospital stay	Facility fee (e.g., hospital room)	$25 copay/confinement	$500 copay/confinement, then 30% coinsurance, plus balance billing; deductible does not apply	Limited to 365 days per illness/injury. Precertification required.
	Physician/surgeon fees	Physician: $15 copay/visit; Surgeon: $25/surgical encounter	$15 copay/visit; $25 copay/surgical encounter, then 20% coinsurance, plus balance billing.	If more than one operation in same field or through one incision, maximum benefit amount is 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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Facility: $15 copay/treatment plan Physician: $15 copay/visit	Facility: $15 copay/treatment plan; deductible does not apply Physician: $15 copay/visit, then 20% coinsurance, plus balance billing; deductible does not apply	Precertification is required for all inpatient admissions, partial hospitalizations and intensive outpatient treatment.
	Inpatient services	Facility: $25 copay/confinement Physician visits: No charge	Facility: $500 copay/confinement, then 30% coinsurance, plus balance billing; deductible does not apply Physician visits: 20% coinsurance, plus balance billing; deductible does not apply.	Precertification is required for all inpatient admissions, partial hospitalizations and intensive outpatient treatment.

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 are pregnant	Office visits	$15 copay/visit	$15 copay/visit, then 20% coinsurance plus balance billing	Limited to a member and legal spouse of a member provided delivery occurs while considered an eligible participant of the Plan. Maternity services not covered for dependent children. Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. Delivery expenses are not covered for dependent children. Plan considers 50% of fee of obstetrician for certified mid-wife. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	$25 copay/delivery	$25 copay, then 20% coinsurance, plus balance billing	
	Childbirth/delivery facility services	$25 copay/facility services	$500 copay/confinement, then 30% coinsurance, plus balance billing; deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance, plus balance billing	Precertification required. Custodial care not covered.
	Rehabilitation services	Speech: $15 copay/visit for visits 1-24; $25 copay/visit thereafter; Physical Therapy and Cardiac Rehab: $15 copay for initial eval. and reeval.	Speech: $15 copay/visit for visits 1-24; $25 copay/visit thereafter; Physical Therapy and Cardiac Rehab: $15 copay for initial eval. and reeval., then 20% coinsurance, plus balance billing	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.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	$25 copay/confinement	$500 copay/confinement, then 30% coinsurance, plus balance billing; deductible 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.
	Durable medical equipment	No charge	20% coinsurance, plus balance billing	Precertification required. Must be medically necessary.
	Hospice services	No charge	20% coinsurance, plus balance billing	Precertification required. Limited to the terminally ill.

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 your child needs dental or eye care	Children's eye exam	$10 copay/exam	Balances over $40 allowance; deductible 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 copay/lenses	Lenses: Balances over allowances Frames: Balances over $50 allowance Deductible does not apply	
	Children's dental check-up	No charge up to Scheduled Allowance	Balances over Scheduled Allowance; deductible does not apply	For patients 19 and over, the maximum payable per calendar year for all dental service is $1,200.

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 • Habilitation services	• Long-term care	• 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)	• Dental Care (Adult)(Limited to $1,200/calendar year maximum) • 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. 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: 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.

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.

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.

■ **The plan's overall deductible**	**$0**
■ **Specialist copay**	**$15**
■ **Hospital (facility) copay**	**$25**
■ **Other copay**	**$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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$240**

■ **The plan's overall deductible**	**$0**
■ **Specialist copay**	**$15**
■ **Hospital (facility) copay**	**$25**
■ **Other copay**	**$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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$260
Coinsurance	$780
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,040**

■ **The plan's overall deductible**	**$0**
■ **Specialist copay**	**$15**
■ **Hospital (facility) copay**	**$25**
■ **Other copay**	**$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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$440
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$440**

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