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, see your SPD. 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: 908-687-4488 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/Individual; **$0**/Family In-network. **$300**/Individual; **$600**/Family Out-of-network.	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 have not 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?	Yes.	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?	**$4,000**/Individual; **$8,000**/Family In-network. Unlimited/ Out-of-network.	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 for out-of-network benefits.
What is not included in the out-of-pocket limit?	Premiums, co-pays, services not covered. Out-of-network cost share.	These costs paid by you are not applied to the out-of-pocket-limit.
Will you pay less if you use a network provider?	Yes. Visit www.Horizonblue.com or call 800-810-2583	If you use an in-network provider, this Plan will pay some or all of the cost of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. If you use an out-of-network provider, this Plan will pay less. See the chart starting on page 2 for how this Plan pays different kinds of providers.
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) 687-4488. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.641funds.org or call (908) 687-4488 for a copy.

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	$20 copay/visit	30% co-insurance after deductible.	Blood work and Diagnostic testing done out-of-network office not covered.
	Specialist visit	$20 copay/visit	30% co-insurance after deductible.	Blood work and Diagnostic testing done out-of-network office not covered.
	Preventive care/screening/ immunization	$20 copay/visit	Not covered	Age and frequency schedule may apply
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay at freestanding lab; $50 copay at freestanding radiology center.	Not covered	$100 copay if done in the outpatient department of an in-network hospital.
	Imaging (CT scans, PET scans, MRIs)	$50 copay for x-ray if done in freestanding facility.	Not covered	All advanced imaging must be preauthorized. $100 copay then 10% coinsurance if done in the outpatient department of an in-network hospital.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available in your	Generic drugs	$7 copay retail $14 copay mail	Not covered	Covers up to 30-day supply (retail prescription). 31-90-day supply (mail order prescription)
	Preferred brand drugs	$25 copay retail $50 copay mail		
	Non-preferred brand drugs	$40 copay retail $80 copay retail		
	Specialty drugs	At mail benefit in above applicable tiers	Not covered	Must use ESI Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None.
	Physician/surgeon fees	10% coinsurance	30% co-insurance after deductible.	None.
	Emergency room care	$150 copay per visit; then 10% coinsurance	$150 copay per visit; then 30% co-insurance	Covered for true medical emergency only.

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 need immediate medical attention	Emergency medical transportation	10% coinsurance	30% co-insurance after deductible.	Up to reasonable and customary. No air ambulance.
	Urgent care	$20 copay/visit	30% co-insurance after deductible.	Blood work and Diagnostic testing done out-of-network office not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	120 days day per year. Pre-certification required.
	Physician/surgeon fees	10% coinsurance	30% co-insurance after deductible.	None.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$20 copay/visit	30% co-insurance after deductible.	None.
	Mental/Behavioral health Inpatient services	10% coinsurance	Not covered	Pre-certification required. Limited to 120 days.
	Substance use disorder outpatient services	$20 copay/visit	30% co-insurance after deductible.	None.
	Substance use disorder Inpatient services	10% coinsurance	Not covered	Pre-certification required. Limited to 120 days detox and 30 days for rehab.
If you are pregnant	Office visits	Prenatal: $20 copay Postnatal: 10% coinsurance	30% coinsurance	Blood work and Diagnostic testing done out-of-network office not covered.
	Childbirth/delivery professional services	10% coinsurance	30% co-insurance after deductible.	None.
	Childbirth/delivery facility services	10% coinsurance	Not covered	Limited to 120 days. Pre-certification is required.
If you need help recovering or have other special health needs	Home health care	$20 copay	Not covered	Limited to 30 visit annual maximum following 3-day hospital stay; RN/LPN only
	Rehabilitation services	$20 copay	Not covered	Limited to 25 visit annual maximum
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	Limited to 30-day maximum. Pre-certification required.
	Durable medical equipment	10% coinsurance	Not covered	
	Hospice services	10% coinsurance	Not covered	Pre-certification required.
	Children's eye exam	No charge	Not covered	In-network only up to Plan maximum. Maximum of one exam per year

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 your child needs dental or eye care	Children's glasses	No charge	Not covered	In-network only up to Plan maximum. Maximum of one pair of frames per year
	Children's dental check-up	No charge	Not covered	$1,500 maximum per year

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.)

- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Pain Management after 2 Treatments per year
- Weight loss programs
- Sleep Apnea after 2 Treatment per year

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

- Vision
- Preventive Care
- Hearing Aids
- Dental Plan
- Chiropractic Care (limited to 25 visits per calendar year)
- Acupuncture (limited to 25 visits per calendar year)
- Dialysis
- Radiation Therapy
- Transplants

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: 908-687-4488. 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 908-687-4488.

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

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 908-687-4488.
[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	$0
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	$0
Copayments	$80
Coinsurance	$735
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$815**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	$0
Copayments	$232
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$432**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	**$3,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$210
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$415**

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