



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 <u>deductible</u> amount before this Plan begins to pay. If you have other family members on the Plan , 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.	This Plan covers some items and services even if you have not yet met the <u>deductible</u> amount, but a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this Plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . Prescription drugs are covered before you meet your deductible. See your SPD for details.
Are there other deductibles for specific services?	Yes.	You must pay all the costs for these services up to the specific <u>deductible</u> 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 <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. This Plan has no <u>out-of-pocket limit</u> for out-of-network benefits. Out-of-pocket limit is only applicable to the Medical benefit not pharmacy benefit.
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 <u>out-of-pocket-limit</u> .
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 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.

 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 SPD	Generic drugs	\$ 7 copay retail \$14 copay mail	Not covered	While Mail Order offers a more economical option, Members may choose between using Mail Order or using a Pharmacy for their prescriptions.
	Preferred brand drugs	\$25 copay retail \$50 copay mail		
	Non-preferred brand drugs	\$40 copay retail \$80 copay mail		
EmpiRx Member Services Toll-free 1-877-241-7123 TDD 1-888-907-0020.	Specialty drugs	At benefit in above applicable tiers	Not covered	Must engage with Payer Matrix for assistance with brand Specialty Drugs (Please See Below)

Payer Matrix Specialty Drug Advocacy Program In Conjunction with EmpiRx		Network Provider (You will pay the least	Out-of- Network Provider	Limitations, Exceptions, & Other Important Information:
If you need a Specialty drug to treat your illness or condition. More information about Specialty prescription drug coverage is available at Payer Matrix 1-877-305-6202 www.Payermatrix.com	Generic drugs (Tier 1)	\$7 Copay per prescription (retail)	Not Covered	<u>Retail with EmpiRX</u> While Mail Order offers a more economical option, Members may choose between using Mail Order or using a Pharmacy. <u>Specialty with Payer Matrix</u> Enrollment with Payer Matrix for specialty medication may qualify for zero copay. Payer Matrix will reach out to you and assist you in obtaining financial assistance with specific specialty drugs. You need to comply with the Payer Matrix process in accessing the manufacturer assistance program. If you are not eligible to enroll in the manufacturer assistance program, your case will be reconsidered with benefits through EmpiRx and will revert to the standard specialty copays . If you are eligible, but refuse to comply with the Payer Matrix process, you will have to pay the full cost of the drug unless you file an appeal, and it is accepted.
	Preferred brand drugs (Tier 2)	\$25 Copay per prescription (retail)		
	Non-preferred brand drugs (Tier 3)	\$40 Copay per prescription (retail);		
	Specialty drugs (Tier 4)	Eligible for manufacturer assistance with Payer Matrix advocacy: No Copay* Not enrolled in Payer Matrix: Not Covered If ineligible to enroll in manufacturer assistance with Payer Matrix advocacy, then benefits reconsidered through EmpiRx: Limited exceptions where a nominal copay may apply		

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not covered	None.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>co-insurance</u> after deductible.	None.
If you need immediate medical attention	Emergency room care	\$150 <u>copay</u> per visit; then 10% <u>coinsurance</u>	\$150 copay per visit; then 30% <u>co-insurance</u>	Covered for true medical emergency only.
	Emergency medical transportation	10% <u>coinsurance</u>	30% <u>co-insurance</u> after deductible.	Up to reasonable and customary. No air ambulance.
	Urgent care	\$20 <u>copay</u> /visit	30% <u>co-insurance</u> 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% <u>coinsurance</u>	Not covered	120 days per year. Pre-certification required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>co-insurance</u> after deductible.	None.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	\$20 <u>copay</u> /visit	30% <u>co-insurance</u> after deductible.	None.
	Mental/Behavioral health Inpatient services	10% <u>coinsurance</u>	Not covered	Pre-certification required. Limited to 120 days.
	Substance use disorder outpatient services	\$20 <u>copay</u> /visit	30% <u>co-insurance</u> after deductible.	None.
	Substance use disorder Inpatient services	10% <u>coinsurance</u>	Not covered	Pre-certification required. Limited to 120 days detox and 30 days for rehab.
If you are pregnant	Office visits	Prenatal: \$20 <u>copay</u> Postnatal: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Blood work and Diagnostic testing done out-of-network office not covered.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>co-insurance</u> after deductible.	None.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not covered	Limited to 120 days. Pre-certification is required.

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

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	\$20 <u>copay</u>	Not covered	Limited to 30 visit annual maximum following 3-day hospital stay: RN/LPN only
	Rehabilitation services	\$20 <u>copay</u>	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% <u>coinsurance</u>	Not covered	
	Hospice services	10% <u>coinsurance</u>	Not covered	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. Maximum of one exam per year
	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 is not 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

Questions: Please Call the Fund Office at (908) 687-4488 if you are not clear about any of the underlined terms used in this form.

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.

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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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 [<i>cost sharing</i>]	\$20
■ Hospital (facility) [<i>cost sharing</i>]	10%
■ Other [<i>cost sharing</i>]	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$80
Coinsurance	\$735
<i>What is not covered</i>	
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 [<i>cost sharing</i>]	\$20
■ Hospital (facility) [<i>cost sharing</i>]	10%
■ Other [<i>cost sharing</i>]	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$232
Coinsurance	\$0
<i>What is not covered</i>	
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 [<i>cost sharing</i>]	\$20
■ Hospital (facility) [<i>cost sharing</i>]	10%
■ Other [<i>cost sharing</i>]	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$210
Coinsurance	\$215
<i>What is not covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$415