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.gov/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.	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 yet 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?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an 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.	This 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	None.
	Other practitioner office visit	Chiropractic: $15 copay/visit	$15 copay/visit, then 20% coinsurance, plus balance billing	Covered services include X-rays, manipulation and subluxation of spine only; maximum 52 visits/person per calendar year.
	Preventive care/screening/ immunization	$15 copay/visit; $25 copay/diagnostic	$15 copay/visit; $25 copay/diagnostic, then 20% coinsurance, plus balance billing	None.
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	Maximum payment is $500/site for MRI performed on other than brain, brain stem & cervical spinal cord. 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	Generic drugs	Not covered	Not covered	Except for chemotherapy medications, you must pay 100% of these expenses, even in-network.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
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	When surgical fee is greater than $100: $25 copay/surgical encounter; When surgical fee is $100 or less: $10 copay/surgical encounter, then 20% coinsurance, plus balance billing	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.
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.

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 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 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.
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/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.
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. Plan considers 50% of fee of obstetrician for certified mid-wife.
	Childbirth/delivery professional services	$25 copay/delivery	$25 copay, then 20% coinsurance, plus balance billing.	

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)	
	Childbirth/delivery facility services	$25 copay/facility charge	$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.	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. Limited to 36 sessions per illness or injury. Further treatment subject to Plan approval.
	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	Balances over $200 daily limit	Precertification required. Limited to the terminally ill.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Children's glasses	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even in-network.

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 • Non-emergency care when traveling outside the U.S.	• Prescription Drugs • Routine eye care (Adult and Child)

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 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 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
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 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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$280**

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 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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$220
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,040
The total Joe would pay is	**$6,260**

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

■ **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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$750
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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