
 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, contact the Fund Office at 1-800-852-0806. 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.tjc83funds.org/summary-benefits.asp](http://www.tjc83funds.org/summary-benefits.asp) or call 1-800-852-0806 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	\$200 per person/\$600 per family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by the family members meets the overall family deductible.
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. PCP and specialist office visits are covered, as well as covered prescription drugs.	This <a href="#">plan</a> covers some items and services even if you haven't met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://healthcare.gov/coverage/preventive-care-benefits/">https://healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	<u>In-network providers:</u> \$2,225 per person \$6,675 per family <u>Out-of-network providers:</u> \$6,675 per person \$20,025 per family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<a href="#">What is not included in the out-of-pocket limit?</a>	Refer to Section 3.16.C of the Plan Document.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket</a> limit.
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 800-810-2583 for a list of <a href="#">network providers</a> .	This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network</a> provider, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<a href="#">Do you need a referral to see a specialist?</a>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	35% co-insurance	Subject to deductible if a non-participating provider is used
	<a href="#">Specialist</a> visit	\$25 copay/visit	35% co-insurance	Subject to deductible if a non-participating provider is used
	<a href="#">Preventive care/screening/immunization</a>	\$15 copay for PCP \$25 copay for specialist	35% co-insurance	Subject to deductible if a non-participating provider is used
If you have a test	<a href="#">Diagnostic test</a> ( blood work)	0% coinsurance	15% co-insurance	Subject to deductible if a non-participating provider is used
	Imaging (CT/PET scans, MRIs)	15% co-insurance	15% co-insurance	Subject to deductible
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.tjc83funds.org">www.tjc83funds.org</a> .	Generic drugs - retail	\$5 minimum; 20% co-insurance	Not covered	30 day supply
	Preferred brand drugs - retail	\$5 minimum; 20% co-insurance	Not covered	30 day supply
	<a href="#">Specialty drugs</a>	\$45	Not covered	30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% co-insurance	35% co-insurance	Subject to deductible
	Physician/surgeon fees	15% co-insurance	35% co-insurance	Subject to deductible
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 copay	\$100 copay	None
	<a href="#">Emergency medical transportation</a>	15% co-insurance	15% co-insurance	Subject to deductible
	<a href="#">Urgent care</a>	\$15 copay	35% co-insurance	Subject to deductible – out-of-network only
If you have a hospital stay	Facility fee (e.g., hospital room)	15% co-insurance	15% co-insurance	Subject to deductible
	Physician/surgeon fees	15% co-insurance	15% co-insurance	120 consecutive days per person per year Admission notification required

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 mental health, behavioral health, or substance abuse services	Outpatient services	15% co-insurance	35% co-insurance	Subject to deductible
	Inpatient services	15% co-insurance	15% co-insurance	Subject to deductible 120 consecutive days per person per year Admission notification required
If you are pregnant	Office visits	\$25 copay	35% co-insurance	None
	Childbirth/delivery professional services	15% co-insurance	15% co-insurance	Subject to deductible 120 consecutive days per person per year
	Childbirth/delivery facility services	15% co-insurance	35% co-insurance	Subject to deductible 120 consecutive days per person per year
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% co-insurance	35% co-insurance	Subject to deductible
	<a href="#">Rehabilitation services</a>	15% co-insurance	35% co-insurance	Subject to deductible
	<a href="#">Habilitation services</a>	15% co-insurance	35% co-insurance	Subject to deductible
	<a href="#">Skilled nursing care</a>	15% co-insurance	35% co-insurance	Subject to deductible
	<a href="#">Durable medical equipment</a>	15% co-insurance	35% co-insurance	Subject to deductible; Requires prior-authorization over \$1,000
	<a href="#">Hospice services</a>	15% co-insurance	35% co-insurance	Subject to deductible
If your child needs dental or eye care	Children's eye exam	\$0 copay	\$35 allowed amount	Subject to frequency maximums
	Children's glasses	Lens - \$0 copay Frames - \$0 copay; \$100 allowable for each	Lens - \$40 allowed amount Frames - \$40 allowed amount	Subject to frequency maximums
	Children's dental check-up	\$0 co-pay	Refer to dental fee schedule	Subject to frequency maximums

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Infertility treatment</li> <li>• Employment related injury or illness</li> <li>• Services occurring when patient not present</li> </ul>	<ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Failure to keep visit charges</li> <li>• Form completion charges</li> </ul>	<ul style="list-style-type: none"> <li>• Any treatment deemed not medically necessary</li> <li>• Reverse sterilization</li> <li>• Charges resulting from an illegal act</li> </ul>

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

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|---|---|--|
| <ul style="list-style-type: none"><li>• Acupuncture (when performed by a physician)</li><li>• Bariatric surgery</li><li>• Dental and vision services for adults</li><li>• Orthodontics for dependent children under the age of 18</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Hearing aids</li><li>• Physical Therapy</li><li>• Speech Therapy</li><li>• Occupational Therapy</li></ul> | <ul style="list-style-type: none"><li>• Most coverage provided outside the United States. See <a href="http://www.anthem.com">www.anthem.com</a>.</li><li>• Short Term Disability</li><li>• Life Insurance</li><li>• Transplants</li></ul> |
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**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 those agencies is: [www.dol.gov](http://www.dol.gov) or [www.hhs.gov](http://www.hhs.gov). 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 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.

**Does this plan provide Minimum Essential Coverage?** Yes. This plan provides Minimum Essential Coverage. 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, this plan meets the Minimum Value Standards. 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 1-800-852-0806.

-----*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](#) \$200
- Hospital (facility) [*cost sharing*] 15%

This EXAMPLE event includes services like:

Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Coinsurance	\$1,890
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,090</b>

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

- The [plan's](#) overall [deductible](#) \$200
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 15%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (blood work)

<b>Total Example Cost</b>	<b>\$1,200</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles (lab work is covered at 100%)	\$0
Copayment (per office visit with specialist)	\$25
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$25</b>

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

- The [plan's](#) overall [deductible](#) \$200
- ER Copay [*cost sharing*] \$100

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments (all services mentioned above are covered under ER copay)	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$100</b>