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 or call 1-800-852-0806 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$375 per person/$1,125 per family	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 deductible until the total amount of deductible expenses paid by the family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. PCP and specialist office visits are covered, as well as covered prescription drugs.	This plan covers some items and services even if you haven't 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 a list of covered preventive services at https://healthcare.gov/coverage/preventive-care-benefits/.
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?	In-network providers: $5,500 per person $16,500 per family Out-of-network providers: $16,500 per person $49,500 per family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Refer to Section 3.16.C of the Plan Document.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 800-810-2583 for a list of network 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 an out-of-network 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 network provider might use an out-of-network 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 a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% co-insurance	Subject to deductible if a non-participating provider is used
	Specialist visit	$30 copay/visit	30% co-insurance	Subject to deductible if a non-participating provider is used
	Preventive care/screening/ immunization	$20 copay for PCP $30 copay for specialist	30% co-insurance	Subject to deductible if a non-participating provider is used
If you have a test	Diagnostic test (blood work)	0% coinsurance	10% co-insurance	Subject to deductible if a non-participating provider is used
	Imaging (CT/PET scans, MRIs)	10% co-insurance	10% co-insurance	Subject to deductible
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.tjc83funds.org.	Generic drugs - retail	$10 minimum; 20% co-insurance	Not covered	30 day supply
	Preferred brand drugs - retail	$10 minimum; 20% co-insurance	Not covered	30 day supply
	Specialty drugs	$60	Not covered	30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	30% co-insurance	Subject to deductible
	Physician/surgeon fees	10% co-insurance	30% co-insurance	Subject to deductible
If you need immediate medical attention	Emergency room care	$150 copay	$150 copay	None
	Emergency medical transportation	10% co-insurance	10% co-insurance	Subject to deductible
	Urgent care	$20 copay	30% co-insurance	Subject to deductible – out-of-network only
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	10% co-insurance	Subject to deductible
	Physician/surgeon fees	20% co-insurance	20% co-insurance	60 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	20% co-insurance	30% co-insurance	Subject to deductible
	Inpatient services	10% co-insurance	10% co-insurance	Subject to deductible 60 consecutive days per person per year Admission notification required
If you are pregnant	Office visits	$30 copay	30% co-insurance	None
	Childbirth/delivery professional services	10% co-insurance	10% co-insurance	Subject to deductible 60 consecutive days per person per year
	Childbirth/delivery facility services	10% co-insurance	30% co-insurance	Subject to deductible 60 consecutive days per person per year
If you need help recovering or have other special health needs	Home health care	20% co-insurance	30% co-insurance	Subject to deductible
	Rehabilitation services	20% co-insurance	30% co-insurance	Subject to deductible
	Habilitation services	20% co-insurance	30% co-insurance	Subject to deductible
	Skilled nursing care	20% co-insurance	30% co-insurance	Subject to deductible
	Durable medical equipment	20% co-insurance	30% co-insurance	Subject to deductible; Requires prior-authorization over $1,000
	Hospice services	20% co-insurance	30% co-insurance	Subject to deductible
If your child needs dental or eye care	Children's eye exam	$10 copay	Charge less $20 insurance payment	Subject to frequency maximums
	Children's glasses	Lens - $0 copay Frames - $10 copay; $74 allowance; 80% of balance over $74	Lens – charge less $20 insurance payment Frames – charge less $20 insurance payment	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Employment related injury or illness
- Services occurring when patient not present
- Custodial care
- Failure to keep visit charges
- Form completion charges
- Chiropractic care
- Hearing aids
- Any treatment deemed not medically necessary
- Reverse sterilization
- Charges resulting from an illegal act

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (when performed by a physician) • Bariatric surgery • Dental and vision services for adults • Orthodontics for dependent children under the age of 18	• Physical Therapy • Speech Therapy • Occupational Therapy	• Most coverage provided outside the United States. See www.anthem.com. • Short Term Disability • Life Insurance • Transplants

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 or 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 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 $375
- Hospital (facility) *[cost sharing]* 10%

This EXAMPLE event includes services like:
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$375
Coinsurance	$1,242.50
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$1,617.50

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

- The plan's overall deductible $375
- Specialist *[cost sharing]* $30
- Hospital (facility) *[cost sharing]* 10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests (blood work)

Total Example Cost	$1,200

In this example, Joe would pay:

Cost Sharing	
Deductibles (lab work is covered at 100%)	$0
Copayment (per office visit with specialist)	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$30

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

- The plan's overall deductible $375
- ER Copay *[cost sharing]* $150

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments (all services mentioned above are covered under ER copay)	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$150

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