




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](http://www.tjc83funds.org) or call 1-800-852-0806 to request a copy.

| Important Questions  | Answers  | Why This Matters:   |
|--|--|---|
| <p><b>What is the overall <a href="#">deductible</a>?</b></p>                                | <p>\$250 per person/\$750 per family</p>   | <p>Generally, you must pay all of the costs from <a href="#">providers</a> 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 individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p> |
| <p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>    | <p>Yes. <a href="#">Primary Care Physician</a> and <a href="#">specialist</a> office visits are covered, as well as covered <a href="#">prescription drugs</a>.</p>  | <p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.</p>  |
| <p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>             | <p>No.</p>   | <p>You don't have to meet <a href="#">deductibles</a> for specific services</p>   |
| <p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p> | <p><u>In-network providers:</u><br/>                 \$2,000 per person<br/>                 \$6,000 per family</p> <p><u>Out-of-network providers:</u><br/>                 \$6,000 per person<br/>                 \$18,000 per family</p> | <p>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.</p>   |

| Important Questions  | Answers   | Why This Matters:   |
|--|---|---|
| What is not included in the <a href="#">out-of-pocket limit</a> ?            | <a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">deductibles</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. 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 limits</a> .  |
| Will you pay less if you use a <a href="#">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 <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> 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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">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<br>(You will pay the least)  | Out-of-Network Provider<br>(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 <a href="#">copay</a> /visit   | 30% <a href="#">coinsurance</a>                    | Subject to deductible if a non-participating provider is used |
|  | <a href="#">Specialist</a> visit                       | \$25 <a href="#">copay</a> /visit   | 30% <a href="#">coinsurance</a>                    | Subject to deductible if a non-participating provider is used |
|  | <a href="#">Preventive care/screening/immunization</a> | \$15 <a href="#">copay</a> for <a href="#">PCP</a><br>\$25 <a href="#">copay</a> for <a href="#">specialist</a> | 30% <a href="#">coinsurance</a>                    | Subject to deductible if a non-participating provider is used |

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.tjc83funds.org](http://www.tjc83funds.org)]

| Common Medical Event  | Services You May Need                            | What You Will Pay                               |  | Limitations, Exceptions, & Other Important Information  |
|---|--|---|--|---|
|   |  | Network Provider<br>(You will pay the least)    | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> ( blood work)    | 0% <a href="#">coinsurance</a>                  | 10% <a href="#">coinsurance</a>                    | If a non-participating provider is used, test(s) must be ordered and/or specimens collected by an in-network facility |
|   | Imaging (CT/PET scans, MRIs)                     | 10% <a href="#">coinsurance</a>                 | 10% <a href="#">coinsurance</a>                    |   |
| <b>If you need drugs to treat your illness or condition</b><br>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;<br>20% <a href="#">coinsurance</a> | Not covered  | 30 day supply   |
|   | Preferred brand drugs - retail                   | \$5 minimum;<br>20% <a href="#">coinsurance</a> | Not covered  | 30 day supply   |
|   | Generic drugs- Home Delivery Program             | \$20 maximum                                    | Not covered  | 90 day supply   |
|   | Brand drugs- Home Delivery Program               | \$45 minimum                                    | Not covered  | 90 day supply   |
|   | Specialty drugs- Home Delivery Program           | \$45 minimum                                    | Not covered  | 30 day supply   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                    | Subject to deductible   |
|   | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a>                 | 30% <a href="#">coinsurance</a>                    | Subject to deductible   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>              | \$100 <a href="#">copay</a> /visit              | \$100 <a href="#">copay</a> /visit                 | None  |
|   | <a href="#">Emergency medical transportation</a> | 10% <a href="#">coinsurance</a>                 | 10% <a href="#">coinsurance</a>                    | Subject to deductible   |
|   | <a href="#">Urgent care</a>                      | \$15 <a href="#">copay</a> /visit               | 30% <a href="#">coinsurance</a>                    | Subject to deductible – out-of-network only   |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)               | 10% <a href="#">coinsurance</a>                 | 10% <a href="#">coinsurance</a>                    | Subject to deductible   |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                 | 20% <a href="#">coinsurance</a>                    | 120 consecutive days per person per year<br>Admission notification required   |

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.tjc83funds.org](http://www.tjc83funds.org)]

| Common Medical Event   | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|---|---|--|
|  |   | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)          |  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                             | Subject to deductible  |
|  | Inpatient services                        | 10% <a href="#">coinsurance</a>   | 10% <a href="#">coinsurance</a>                             | Subject to deductible<br>120 consecutive days per person per year<br>Admission notification required |
| <b>If you are pregnant</b>   | Office visits                             | \$25 <a href="#">copay</a> /visit   | 30% <a href="#">coinsurance</a>                             | None.  |
|  | Childbirth/delivery professional services | 10% <a href="#">coinsurance</a>   | 10% <a href="#">coinsurance</a>                             | Depending on the type of services, a <a href="#">coinsurance</a> may apply.                          |
|  | Childbirth/delivery facility services     | 10% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                             |  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                             | Subject to deductible  |
|  | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                             | Subject to deductible.   |
|  | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                             |  |
|  | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                             | Subject to deductible  |
|  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                             | Subject to deductible; Requires prior-authorization over \$1,000                                     |
|  | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                             | Subject to deductible  |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | \$0 <a href="#">copay</a> /visit  | \$35 allowed amount   | Subject to frequency maximums  |
|  | Children's glasses                        | Lenses - \$0 <a href="#">copay</a> /visit<br>Frames - \$0 <a href="#">copay</a> /visit;<br>\$100 allowable for each | Lenses – \$40 allowed amount<br>Frames –\$40 allowed amount | Subject to frequency maximums  |
|  | Children's dental check-up                | \$0 <a href="#">copay</a> /visit  | Refer to dental fee schedule                                | Subject to frequency maximums  |

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## 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](#).)

- Any treatment deemed not medically necessary
- Charges resulting from an illegal act
- Cosmetic surgery
- Custodial care
- Employment related injury or illness
- Failure to keep visit charges
- Form completion charges
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Reverse sterilization
- Services occurring when patient not present
- Weight loss programs

### 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
- Chiropractic care (12 visits per calendar year)
- Dental care (Adult) (\$3,000 annual maximum)
- Hearing aids (One hearing aid per ear ever five years)
- Routine eye care (Adult) (Only one eye exam is payable per calendar year. A set of contact lenses and a set of frames and lenses are payable during a calendar year.)

**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 on how 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.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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 1-800-852-0806.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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](#) \$250
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$250          |
| <a href="#">Copayments</a>        | \$30           |
| <a href="#">Coinsurance</a>       | \$1,100        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,440</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a> *     | \$250          |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$900          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,370</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a> *     | \$250        |
| <a href="#">Copayments</a>        | \$200        |
| <a href="#">Coinsurance</a>       | \$200        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$650</b> |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Fund Office at 1-800-852-0806.

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.