




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:
What is the overall <a href="#">deductible</a> ?	\$250 individual/\$750 family	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	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. 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://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">in-network providers</a> \$2,000 individual/\$6,000 family; for <a href="#">out-of-network providers</a> \$6,000 individual/ \$18,000 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. Under the No Surprises Act cost-sharing at certain <a href="#">out-of-network providers</a> applies to the <a href="#">out-of-pocket limit</a> .
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 3.17.B 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.

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

Important Questions	Answers	Why This Matters:
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 <a href="#">copayment</a> and <a href="#">coinsurance</a> costs shown in this chart are after your <a href="#">deductible</a> has been met, if a <a href="#">deductible</a> 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 office</a> or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> if an <a href="#">out-of-network provider</a> is used
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> if an <a href="#">out-of-network provider</a> is used
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (blood work)	No charge	10% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> is used, test(s) must be ordered and/or specimens collected by an <a href="#">in-network</a> facility
	Imaging (CT/PET scans, MRIs)	No charge during office visit; all others 10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
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	20% <a href="#">coinsurance</a> with a \$5 <a href="#">copay</a> minimum	Not covered	Covers up to a 30-day supply
	Preferred brand drugs - retail	20% <a href="#">coinsurance</a> with a \$5 <a href="#">copay</a> minimum	Not covered	Covers up to a 30-day supply
	Generic drugs- Home Delivery Program	\$20 <a href="#">copay</a>	Not covered	Covers up to a 90-day supply
	Brand drugs- Home Delivery Program	\$45 <a href="#">copay</a>	Not covered	Covers up to a 90-day supply
	Specialty drugs- Home Delivery Program	\$20 <a href="#">copay</a> minimum (generics) or \$45 (brand)	Not covered	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>

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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)	
	Physician/surgeon fees	Surgical in-network 10% <a href="#">coinsurance</a> ; other services 20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit	\$100 <a href="#">copay</a> /visit	<a href="#">Out-of-network</a> Emergency, Air Ambulance, and Ancillary Services are payable at the in-network rate.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
	<a href="#">Urgent care</a>	\$15 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> – <a href="#">out-of-network</a> only
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> ; 120 consecutive days per person per year; <a href="#">preauthorization</a> required
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
	Inpatient services	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> ; 120 consecutive days per person per year; <a href="#">preauthorization</a> required
If you are pregnant	Office visits	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> – <a href="#">out-of-network</a> only
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Depending on the type of services, <a href="#">deductible</a> and <a href="#">coinsurance</a> may apply.
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> .
	<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 <a href="#">deductible</a>

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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)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> ; <a href="#">preauthorization</a> required for amounts over \$1,000
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Billed charges above \$35 allowed amount	Subject to frequency maximums
	Children's glasses	Lenses and frames – no charge up to \$100 allowance each. 80% of charges above allowance	Lenses and frames – billed charges above \$40 allowed amount	Subject to frequency maximums
	Children's dental check-up	No charge	Refer to dental fee schedule	Subject to frequency maximums

**Excluded Services & Other Covered Services:**

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

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>Acupuncture (when performed by a physician)</li> <li>Bariatric surgery</li> <li>Chiropractic care (12 visits per calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult) (\$3,000 annual maximum)</li> <li>Hearing aids (One hearing aid per ear ever five years)</li> </ul>	<ul style="list-style-type: none"> <li>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.)</li> </ul>

**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	20%

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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,310</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	20%

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>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,570</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	20%

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$300
<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.

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