



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$250 individual/\$750 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>in-network providers</u> \$2,000 individual/\$6,000 family; for <u>out-of-network providers</u> \$6,000 individual/\$18,000 per family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. Under the No Surprises Act cost-sharing at certain <u>out-of-network providers</u> applies to the <u>out-of-pocket limit</u> .
What is not included in the out-of-pocket limit?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>deductibles</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> 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 <u>out-of-pocket limits</u> .
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
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	\$15 copay /visit	30% coinsurance	Subject to deductible if an out-of-network provider is used
	Specialist visit	\$25 copay /visit	30% coinsurance	Subject to deductible if an out-of-network provider is used
	Preventive care/screening/immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (blood work)	No charge	10% coinsurance	If an out-of-network provider is used, test(s) must be ordered and/or specimens collected by an in-network facility
	Imaging (CT/PET scans, MRIs)	No charge during office visit; all others 10% coinsurance	10% coinsurance	
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	\$0 copay	Not covered	Covers up to a 30-day supply
	Tier 2 preferred brand drugs – retail	20% coinsurance with a \$5 copay minimum	Not covered	Covers up to a 30-day supply
	Tier 3 non-preferred brand drugs – retail	20% coinsurance with a \$5 copay minimum	Not covered	Covers up to a 30-day supply
	Generic drugs – Home Delivery Program	\$0 copay	Not covered	Covers up to a 90-day supply
	Tier 2 preferred brand drugs – Home Delivery Program	\$45 copay	Not covered	Covers up to a 90-day supply
	Tier 3 non-preferred brand drugs – Home Delivery Program	\$45 copay	Not covered	Covers up to a 90-day supply
	Specialty drugs – Home Delivery Program	\$0 copay minimum (generics) or \$45	Not covered	Covers up to a 30-day supply

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

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

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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)	
	Durable medical equipment	20% coinsurance	30% coinsurance	Subject to deductible ; preauthorization required for amounts over \$1,000
	Hospice services	20% coinsurance	30% coinsurance	Subject to deductible
If your child needs dental or eye care	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 \$130 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:

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 appointment 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
- Services related to conditions on the autism spectrum
- Weight loss programs including GLP-1 drugs for weight loss purposes

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 every 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 or www.hhs.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health](#)

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[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 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.

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	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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing

Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,710

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	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$250
Copayments	\$200
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,170

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	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing

Deductibles	\$250
Copayments	\$200
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$750

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.