



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:
<b>What is the overall deductible?</b>	\$300 individual/\$900 per 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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Primary care physician</u> and <u>specialist</u> office visits are covered, as well as covered <u>prescription drugs</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.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For <u>network providers</u> \$5,500 individual/\$16,500 family; for <u>out-of-network providers</u> \$16,500 individual/\$49,500 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> .
<b>What is not included in the out-of-pocket limit?</b>	<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 3.16.C of the Plan Document.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limits</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> 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</u> charge 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 <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> .
<p> 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.</p>		

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 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> if an <a href="#">out-of-network provider</a> is used
	Specialist visit	\$30 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> if an <a href="#">out-of-network provider</a> is used
	Preventive care/screening/immunization	\$20 <a href="#">copay</a> for <a href="#">PCP</a> \$30 <a href="#">copay</a> for <a href="#">specialist</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> if an <a href="#">out-of-network provider</a> is used
If you have a test	<a href="#">Diagnostic test</a> (blood work)	No charge	15% <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 in- <a href="#">network</a> facility
	Imaging (CT/PET scans, MRIs)	No charge during office visit; all other 15% <a href="#">coinsurance</a>	15% <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	\$0 <a href="#">copay</a>	Not covered	Covers up to a 30-day supply
	Tier 2 preferred brand drugs – retail	20% <a href="#">coinsurance</a> with a \$10 <a href="#">copay</a> minimum	Not covered	Covers up to a 30-day supply
	Tier 3 non-preferred brand drugs – retail	20% <a href="#">coinsurance</a> with a \$10 <a href="#">copay</a> minimum	Not covered	Covers up to a 30-day supply
	Generic drugs - Home Delivery Program	\$0 <a href="#">copay</a>	Not covered	Covers up to a 90-day supply
	Tier 2 preferred brand drugs - Home Delivery Program	\$60 <a href="#">copay</a>	Not covered	Covers up to a 90-day supply
	Tier 3 non-preferred drugs – Home Delivery Program	\$60 <a href="#">copay</a>	Not covered	Covers up to a 90-day supply
	Specialty drugs- Home Delivery Program	\$0 <a href="#">copay</a> (generics) or \$60 <a href="#">copay</a> (brand)	Not covered	Covers up to a 30-day supply
	If you have outpatient	Facility fee (e.g.,	15% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>

[\* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
surgery	ambulatory surgery center)			
	Physician/surgeon fees	Surgical in-network 15% <a href="#">coinsurance</a> ; other services 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit	\$150 <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>	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> /visit	40% <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)	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> . 60 cumulative days per person per year. <a href="#">Preauthorization</a> required.
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
	Inpatient services	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> . 60 cumulative days per person per year. <a href="#">Preauthorization</a> required.
If you are pregnant	Office visits	\$30 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> – <a href="#">out-of-network</a> only
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a>	15% <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	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
	<a href="#">Rehabilitation services</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
	<a href="#">Habilitation services</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a>
	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Subject to <a href="#">deductible</a> ; preauthorization

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)	
	Hospice services	15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	required for amounts over \$1,000 Subject to <a href="#">deductible</a>
If your child needs dental or eye care	Children's eye exam	\$10 <a href="#">copay</a> /visit	Billed charges over \$20 allowed amount	Subject to frequency maximums
	Children's glasses	Lenses and frames – no charge up to \$100 allowance for each. 80% of charges above allowance.	Lenses – billed charges over \$20 allowed amount Frames – billed charges over \$20 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

#### 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
- Dental care (Adult)
- 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](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.*

## 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>	\$300
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

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**

**In this example, Peg would pay:**

Cost Sharing

[Deductibles](#) \$300

[Copayments](#) \$0

[Coinsurance](#) \$1,600

*What isn't covered*

Limits or exclusions \$60

**The total Peg would pay is** **\$1,960**

### 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>	\$300
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

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**

**In this example, Joe would pay:**

Cost Sharing

[Deductibles\\*](#) \$300

[Copayments](#) \$200

[Coinsurance](#) \$700

*What isn't covered*

Limits or exclusions \$20

**The total Joe would pay is** **\$1,220**

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

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**

**In this example, Mia would pay:**

Cost Sharing

[Deductibles\\*](#) \$300

[Copayments](#) \$200

[Coinsurance](#) \$300

*What isn't covered*

Limits or exclusions \$0

**The total Mia would pay is** **\$800**

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.