Indiana/Kentucky/Ohio Regional Council of Carpenters' Fringe Benefit Funds

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June 2023

To: **All Participants of the Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Plan**

From: **Board of Trustees of the Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Plan**

Please read this Notice carefully. It contains important information about changes to the Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Plan (Plan). Please keep this notice with your Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Fund Summary Plan Description (SPD).

1. OUT-OF-NETWORK RATE

As you know, effective January 1, 2023, Independence Blue Cross (Independence) replaced Anthem Blue Cross as your medical network provider, and medical claims are now paid by Independence Administrators (IA) instead of BeneSys. This notice clarifies how the Plan pays claims from out-of-network providers and facilities effective 1/1/23.

Prior to 1/1/23, the amount paid by the Plan for out-of-network claims was 60% of the amount determined to be "Reasonable and Customary." "Reasonable and Customary," in general, is the amount charged by most providers providing like services in the geographic area where the services are rendered.

As a result of the transition to Independence, out-of-network claims are now paid based on Medicare Rates instead of "Reasonable and Customary" amounts, as follows:

- For institutional procedures, the Plan will pay 60% of 150% of the applicable Medicare rate.
- For professional procedures, the Plan will pay 60% of 100% of the applicable Medicare rate.
- Where there is no Medicare rate available, the Plan will pay 60% of 50% of actual charges.

For example:

- The Plan receives an out of network charge of $1,000 for a non-emergency elective institutional procedure and the applicable Medicare Rate is $500. Assuming the deductible is met, the Plan will pay $450, calculated as follows: 60% multiplied by $750 (150% of $500.00) = $450

- The participant is responsible to pay 40% of the approved charge, which is $300.00 (40% of $750).

- The participant may also be responsible for any additional balance billing assessed by the provider, which in this example would be another $250 - the original charge of $1,000 less $450 paid by the Plan and the $300 co-insurance paid by the participant leaves a $250 balance.

As seen in this example, any balance owed to an out-of-network provider after the Plan makes payment remains the participant's responsibility – this is known as balance billing (subject to exceptions, such as Emergencies for which you cannot be balance billed). **Therefore, we encourage you to use in-network providers to save costs for yourself and the Plan.**

2. EXPIRATION OF EXTENDED PLAN DEADLINES

Due to the National Emergency, beginning March 1, 2020, the deadlines below were extended until the earlier of either (1) one year from the individual's original deadline as stated in the Plan; or (2) 60 days after the announced end of the National Emergency as declared by the President (referred to as the Outbreak Period). This deadline extension applied to these calculations:

- The COBRA election period;
- Timely payment of COBRA premiums;
- Timely notice from covered person of a COBRA qualifying event;
- Timely notice from the plan to a covered person that they may elect COBRA;
- Timely election of HIPAA Special Enrollment rights;
- Timely filing of claims;
- Timely filing of appeals; and
- Timely filing of requests for external review.

The National Emergency ended on May 11, 2023, and therefore the above extended deadlines will expire on July 10, 2023 (i.e., the end of the Outbreak Period mentioned above). Without these extended deadlines, the deadlines in the Plan will revert to those in place before the National Emergency, i.e. the Plan deadlines set forth in the Plan.

3. CHANGES TO APPEAL PROCESS EFFECTIVE JANUARY 1, 2023

Effective January 1, 2023, all appeals should be submitted directly to Independence Administrators at: Independence Administrators, Appeals Department, PO Box 21974, Eagan, MN 55121. You will soon be receiving a new Summary Plan Description detailing the Appeals Process.

4. CHANGES TO CORONAVIRUS/COVID-19 BENEFITS EFFECTIVE MARCH 14, 2023

Effective March 14, 2023, the Plan changed how it covers treatment and testing of COVID-19.

COVID-19 TESTING

The Plan will no longer cover COVID-19 Testing at 100% for both in and out-of-network. Coverage for COVID-19 Testing is now covered as follows:

Medical Benefits	In-Network	Out-Of-Network
COVID-19 testing	75% after deductible	60% of Applicable Medicare Rate after deductible

TREATMENT OF COVID-19

Treatment of COVID-19 will no longer be covered In-Network at 100%. Treatment of COVID-19 is now covered as follows:

Medical Benefits	In-Network	Out-Of-Network
Treatment for COVID-19	75% after deductible	60% of Applicable Medicare Care Rate after deductible

OTC COVID-19 TESTS

The Plan will continue to cover FDA approved OTC COVID-19 Tests purchased for person use (e.g., not for employment purposes or resale) through December 31, 2023 as follows:

Medical Benefits	In-Network	Out-Of-Network
OTC COVID-19 Testing – FDA approved tests purchased on or after January 15, 2022 through December 31, 2023, for personal use (e.g., not for employment purposes or resale) Maximum 8 tests per 30 day period per covered person Note: OTC COVID-19 tests covered via Pharmacy Benefit Manager.	100% coverage at retail and via direct to consumer shipping options provided by Pharmacy Benefit Manager	60% of Applicable Medicare Rate after deductible

OTC COVID-19 Tests purchased after December 31, 2023, will be covered via normal cost sharing as set forth in the Plan.

5. CHANGES TO COVERAGE FOR ABORTION EFFECTIVE JUNE 9, 2023

Currently, the Plan covers therapeutic abortions for Participants and eligible Spouses. In addition, the Plan also covers abortions in the case of rape, incest, or to save the life of the Participant or eligible spouse.

Effective June 9, 2023, the Plan will cover the following:

- Therapeutic abortions for Participants and eligible Spouses and Dependents; and
- Abortions in the case of rape, incest, ectopic pregnancy, missed miscarriage, missed abortion, silent miscarriage, or to save the life of the Participant or eligible Spouse or Dependent.

6. CHANGES TO COBRA RATES EFFECTIVE SEPTEMBER 1, 2023

Effective September 1, 2023, the COBRA rates are as follows:

Medical, Prescription, Dental, and Vision Coverage:

- Current rate: $1,151.00 per month;
- New rate: $1,180.00 per month

Extended Disability:

- Current rate: $1,693.00 per month
- New rate: $1,735.00 per month

7. CHANGES TO PRE AND POST NATAL CARE THAT IS NOT PREVENTIVE CARE EFFECTIVE JANUARY 1, 2022

Effective January 1, 2022, Pre and Post Natal Care that is not considered preventive care will be covered as follows:

In-Network: 75% after deductible
Out-Of-Network: 60% of the Applicable Medicare Rate after deductible.

8. CHANGES TO PROSTEHTIC COVERAGE EFFECTIVE MARCH 2, 2022

Under the Plan, Prosthetics are covered In-Network at 75% after deductible and Out-Of-Network at 60% of the Applicable Medicare Rate after deductible. Effective March 2, 2022, coverage for prosthetics includes cranial prosthetics medically necessary due to hair loss resulting from medical conditions such as alopecia areata or chemotherapy.

9. ADDITION OF EXCLUSION FOR SERVICES, ITEMS, CONDITION OR EXPENDITURE RECEIVED OUTSIDE OF THE UNITED STATES OF AMERICA EFFECTIVE MARCH 2, 2022

Effective March 2, 2022, the following exclusion has been added to the Plan for any services, items, condition, or expenditure:

Received outside of the United States of America for a non-Emergency Medical Condition (charges will only be covered for medical services necessary to treat an Emergency Medical Condition in a foreign county and will not include charges for travel or repatriation).

10. ADDITION OF COVERAGE FOR ORTHDONTIC TREATMENT EFFECTIVE AUGUST 1, 2022

Effective August 1, 2022, orthodontic treatment up to age 19 will be covered under dental benefits subject to a $1,500.00, lifetime maximum benefit. This $1,500.00 lifetime maximum benefit is not included in the general $1,000 dental lifetime maximum benefit.

In other words, you or your covered dependents may receive up to $1,500.00 in orthodontic treatment up to age 19 and $1,000 in dental treatment/services during you or your covered dependents lifetime.

11. CHANGES TO COBRA QUALIFYING EVENT EXTENSION EFFECTIVE DECEMBER 1, 2022

Effective December 1, 2022, in addition to the disability extension and the second qualifying event extension already detailed in the Plan, an additional six-month extension was added to the Plan for a Participant that has an application for Social Security disability benefits pending with the Social Security Administration. Specifically, the extension provides:

Application for Social Security Disability Award Pending

A Participant will be eligible for up to a six-month extension of COBRA continuation coverage, provided:

(A) The Participant has exhausted their Dollar Bank, their ability to make self-payments, and their COBRA continuation coverage;

(B) At the time the Participant qualified for COBRA continuation coverage, the Participant had thirty years of credited service in the Indiana/Kentucky/Ohio Regional Council of Carpenters Pension Fund; and

(C) The Participant has an application for Social Security disability benefits pending with the Social Security Administration.

12. COVERAGE FOR AUTISM SPECTRUM DISORDER (ASD) AND ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER (ADHD) EFFECTIVE DECEMBER 8, 2022

Effective December 8, 2022, the Plan will provide coverage for treatment and services related to ASD and ADHD. Please be advised that all exclusions listed in the Plan document still apply.

13. SAVEON SP

As a reminder, Specialty Drugs are available through the SaveonSP Program. This program provides manufacturer assistance to provide specialty drugs at a lower cost. A list of these drugs, which changes from time to time, is available at the Fund Office and by calling SaveonSP at 1-800-683-1074.

Specialty drugs covered by the SaveonSP Program are subject to the following copayments:

- 0% copayment if the Covered Person timely enrolls in the SaveonSP Program; or
- the copayment assigned by the SaveonSP Program. These copayments may be thousands of dollars per month, and do not count towards the maximum out of pocket amounts set forth in section 3.3(d), above.

14. PRESCRIPTION DRUG COVERAGE FOR ACTIVES AND NON-MEDICARE RETIREE AND DEPENDENTS

As a reminder, the following copayments apply to prescription drugs purchased in-network:

Retail (up to 30 day supply)* (first three refills of same drug)		
Tier 1	Generic:	$20
Tier 2	Formulary Brand:	$40
Tier 3	Non-formulary Brand:	$80
Tier 4	Specialty:	25% up to $200

Retail (up to 30 day supply)* (fourth or more refills of same drug)		
Tier 1	Generic:	100% up to $100
Tier 2	Formulary Brand:	100% up to $100
Tier 3	Non-formulary Brand:	100% up to $100
Mail Order (up to 90 day supply)*		
Tier 1	Generic:	$50
Tier 2	Formulary:	$100
Tier 3	Non-Formulary Brand:	$200
Tier 4	Specialty:	25% up to $200

15. PRESCRIPTION DRUG COVERAGE FOR MEDICARE ELIGIBLE PARTICIPANTS AND DEPENDENTS

As a reminder, Medicare eligible Participants and Dependents who are covered by the fully insured Medicare Policy through Humana, have prescription drug benefits under an Employer Group Waiver Plan (EGWP). The following is a summary of the EGWP. Benefits, formulary, pharmacy network, premiums and/or co-payments/coinsurance may change on January 1 of each year.

EGWP

The amount of coverage depends upon the annual out of pocket costs incurred by a Covered Person, as follows:

Deductible Stage: $200 deductible must be paid by each Covered Person before coverage provided by Plan.

Initial Coverage Stage: After deductible satisfied, Covered Person pays the following copayments until a Covered Person's total annual drug cost (what the Covered Person and Plan pay, combined) equals the CMS Standard to enter the Coverage Gap (in 2022, this is $4,430; in 2023, this is $4,660):

Retail (up to 31-day supply)		
Tier 1	Generic:	$10
Tier 2	Preferred Brand:	$38
Tier 3	Non-Preferred Brand:	$63
Retail (32-to-60-day supply)*		
Tier 1	Generic:	$20
Tier 2	Preferred Brand:	$76
Tier 3	Non-Preferred Brand:	$126
Retail (up to 90-day supply) **		
Tier 1	Generic:	$30
Tier 2	Preferred Brand:	$114
Tier 3	Non-Preferred Brand:	$189
Smart 90 Pharmacies		
Tier 1	Generic:	$17.50
Tier 2	Preferred Brand:	$95.00
Tier 3	Non-Preferred Brand:	$159
Tier 4	Specialty:	N/A

Mail Order (up to 90-day supply)		
Tier 1	Generic:	$17.50
Tier 2	Preferred Brand:	$95.00
Tier 3	Non-Preferred Brand:	$159

*Does not apply to Smart 90 pharmacies.
** Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.

Coverage Gap Stage: After annual total costs (Covered Person and Plan) equal the CMS Standard to enter the Coverage Gap (in 2022, this is $4,430; in 2023, this is $4,660), a Covered Person will pay the following copayments until his/her own out-of-pocket drug costs reach the CMS TrOOP Limit to enter Catastrophic Coverage (in 2022 this is $7,050; in 2023 this is $7,400):

Retail (up to 31-day supply)		
Tier 1	Generic:	$10
Tier 2	Preferred Brand:	$38
Tier 3	Non-Preferred Brand:	$63
Retail (32-to-60-day supply)		
Tier 1	Generic:	$20
Tier 2	Preferred Brand:	$76
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Tier 1	Generic:	$17.50
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Mail Order (up to 90-day supply)		
Tier 1	Generic:	$17.50
Tier 2	Preferred Brand:	$95.00
Tier 3	Non-Preferred Brand:	$159

*Does not apply to Smart 90 pharmacies.
** Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.

Catastrophic Coverage Stage: After a Covered Person's yearly out-of-pocket drug costs reach the CMS TrOOP Limit to enter Catastrophic Coverage (in 2022 this is $7,050; in 2023 this is $7,400), a Covered Person will pay the greater of 5% coinsurance or:

- a $3.95 for 2022 ($4.15 for 2023, subject to further annual adjustment) copayment for covered generic drugs, not to exceed the copayment that would be charged if the Covered Person was in the Initial Coverage stage, or
- a $9.85 for 2022 ($10.35 for 2023, subject to further annual adjustment) copayment for all other covered drugs, not to exceed the copayment that would be charged if the Covered Person was in the Initial Coverage stage.

Provisions applicable to all Coverage Stages:

- The Plan may require Covered Persons to try one drug to treat a condition before it will cover another drug for that same condition (e.g., step therapy), or require prior authorization prior to filling a prescription. Contact the PBM for this information.
- If the actual cost of a drug is less than the co-payment for that drug, the Covered Person will pay the actual cost.

16. COVERAGE FOR WEIGHT LOSS DRUGS

As a reminder, certain weight loss drugs are covered under the Plan's Prescription Drug Program. For more information, please contact the Fund Office.

17. CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

As a reminder, under CHIPRA, you or your dependents who are eligible for coverage, but are not enrolled in coverage, may have special enrollment rights and enroll in the Plan if you or your dependent:

(a) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; or
(b) loses coverage under State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act; or
(c) becomes eligible for group health plan premium assistance under Medicaid or SCHIP.

If any of these circumstances arises and you or your dependent wishes to take advantage of these special enrollment rights, you or your dependent must request to enroll for coverage within 60 days from the date:

(a) the coverage terminates under the Medicaid Plan or SCHIP; or
(b) the Participant or Dependent child is determined eligible for state premium assistance.

If you believe you are eligible for special enrollment under CHIP, you must contact the Fund Office to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by the Fund Office. Requests for special enrollment must be made within 60 days after an event described above.

18. IMPORTANT PHONE NUMBERS

Here is a list of important phone numbers:

Medical Claims:	Contact Independence Administrators (IA) at 1-833-242-3330.
Medicare Claims:	Contact Humana at 800-733-9064.
All Benefit Questions Other than Medical:	Contact BeneSys at 800-700-6756.
Eligibility:	Contact BeneSys at 800-700-6756.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE FUND OFFICE AT 800-700-6756.

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Important Fund Information