



Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Fund

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(317) 851-4168 ■ (800) 700-6756

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IMPORTANT NOTICE

Dear Plan Participant:

This notice contains important information regarding coverage in the Indiana/Kentucky/Ohio Regional Council of Carpenters' Health Plan ("the Plan"). Please read this notice carefully.

If you have any questions regarding the content of this notice, or your coverage in general, please contact the Fund Office at (317) 851-4168 or Toll Free (800) 700-6756.

Summary of Benefits and Coverage

Enclosed please find your Summary of Benefits and Coverage ("SBC"), which is provided annually.

The Summary of Benefits and Coverage includes three parts:

- Benefits and Coverage Information
- Coverage Examples
- Questions and Answers about Coverage Examples

Please consult the Summary Plan Description for a more complete and detailed explanation of benefits and coverage.

Benefits and Coverage Information

This section includes a chart that lists various features of the Plan's medical coverages. It also provides information about coverage for different services, such as office visits, prescription drugs, and emergency room services.

Coverage Examples

The coverage examples on the last page of the SBC show how the Fund might cover medical care for three specific scenarios, and address frequently asked questions regarding coverage examples. The examples show what the Fund would pay and what the patient would pay based on a common set of assumptions. It is important to note that these are examples only. They should not be used to estimate your actual costs under the Plan.



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, call (800) 700-6756. 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 <https://www.healthcare.gov/sbc-glossary/> or call (800) 700-6756 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$500/individual or \$1,250/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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>In-network preventive care</u> and Dental Preventive Care 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.
<u>Are there other deductibles for specific services?</u>	Yes. Dental Benefits - \$100 each calendar year. There are no other specific <u>deductibles</u>	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
<u>What is the out-of-pocket limit for this plan?</u>	Medical: \$5,000/individual or \$10,000/family Prescription: \$1,850/individual or \$3,450/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.
<u>What is not included in the out-of-pocket limit?</u>	Chiropractic benefits, Smoking Cessation benefits, LiveHealth Online Doctor Visit, <u>deductibles</u> , <u>out-of-network</u> charges in excess of <u>plan</u> allowances, <u>premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. 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.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Anthem LiveHealth Online – \$20 <u>copayment</u> , no <u>deductible</u> or <u>coinsurance</u> . Anthem LiveHealth Online is an <u>In-Network</u> Benefit only – no coverage for any telemedicine program other than Anthem LiveHealth Online.
	<u>Specialist</u> visit			-----none-----
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	<u>In-network providers</u> not subject to the <u>deductible</u> . <u>Plan</u> covers <u>preventive services</u> and supplies required by ACA. Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition For more information about <u>prescription drug coverage</u> contact the Fund Office at (800) 392-8726.	Generic drugs	Retail - \$20 (for 1 st 3 fills of same drug); 100% up to \$100 (for 4 th or more fills of same drug) Mail Order - \$50	Not covered	Retail is up to 30-day supply. Mail Order is 90-day supply.
	Formulary brand drugs	Retail - \$40 (for 1 st 3 fills of same drug); 100% up to \$100 (for 4 th or more fills of same drug) Mail Order - \$100		If generic equivalent is available; you will be required to pay the price difference between the generic drug and the formulary brand name drug unless prescription notes "dispense as written." The difference that you pay will not apply to the annual <u>out-of-pocket limit</u> .
	Non-formulary brand drugs	Retail - \$80 (for 1 st 3 fills of same drug); 100% up to \$100 (for 4 th or more fills of same drug) Mail Order – 25% up to \$200		
	<u>Specialty drugs</u>			

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	25% coinsurance after \$250 copayment	40% coinsurance after \$250 copayment	\$250 copayment waived if condition is life threatening or patient is immediately admitted to hospital.
	Emergency medical transportation	25% coinsurance	40% coinsurance	-----none-----
	Urgent care	25% coinsurance after \$75 copayment	40% coinsurance after \$75 copayment	Anthem LiveHealth Online – \$20 copayment , no deductible or coinsurance . Anthem LiveHealth Online is an In-Network Benefit only – no coverage for any telemedicine program other than Anthem LiveHealth Online.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	40% coinsurance	Benefits based on hospital's average semi-private room rate.
	Physician/surgeon fees			-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	40% coinsurance	-----none-----
	Inpatient services			Residential Treatment Facility must be an in-network facility .
If you are pregnant	Office visits	25% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). Pregnancy of a dependent child not covered.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			Inpatient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery. Pregnancy of a dependent child not covered.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	40% coinsurance	Must be homebound
	Rehabilitation services			-----none-----
	Habilitation services	Not covered	Not covered	-----none-----
	Skilled nursing care	25% coinsurance	Not covered	In-network facilities only – for rehabilitation services only.

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)	
	<u>Durable medical equipment</u> <u>Hospice services</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge after \$10 <u>copayment</u>	No charge up to \$45 <u>copayment</u>	Limited to once every 12 months.
	Children's glasses	Frames – No charge up to \$120 after \$15 <u>copayment</u> , then 20% discount. Lenses – No charge; (no separate <u>copayment</u> included in Frames <u>copayment</u>)	Frames – No charge up to \$70. Lenses – No charge up to: Single - \$30 Bifocal - \$50 Trifocal - \$65 Lenticular - \$100	Limited to once every 24 months.
	Children's dental check-up	No charge	No charge up to the <u>out-of-network</u> allowed amount.	Preventive dental services are not subject to dental <u>deductible</u> .

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u>.)			
• Acupuncture	• Habilitation services	• Non-emergency care when traveling outside the U.S.	• Non-emergency care when traveling outside the U.S.
• Cosmetic surgery (unless Medically Necessary)	• Infertility treatment	• Routine foot care	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
• Bariatric surgery (if Plan guidelines are met)	• Dental care (adult)	• Private-duty nursing (if Plan guidelines are met)	• Routine eye care (adult)
• Chiropractic care	• Hearing aids		

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: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), visit www.HealthCare.gov or call (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 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 at (800) 700-6756 or the Department of Labor's Employee Benefits Security Administration at (866) EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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](http://Marketplace.gov).

Language Access Services:

Para obtener asistencia en Español, llame al (800) 700-6756.

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	\$500
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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:

<u>Cost Sharing</u>	
Deductibles	\$500
Copayments	\$40
Coinsurance	\$3,100

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$3,700

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	\$7,500
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In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles	\$500
Copayments	\$800
Coinsurance	\$700

What isn't covered

Limits or exclusions	\$60
The total Joe would pay is	\$2,000

Mia's Simple Fracture

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

■ The plan's overall deductible	\$500
■ Specialist coinsurance	25%
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	\$2,000
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In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$500

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$1,000

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