



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

P.O. Box 969, Troy, MI 48099-0969
Phone: (800) 700-6756

December 2023

IMPORTANT NOTICE

Dear Plan Participant:

This notice contains important information regarding coverage in the Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Fund ("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/Questions and Answers

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:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers. This is a Medicare Advantage plan.
Are there services covered before you meet your deductible ?	Not Applicable	This plan does not have a deductible . This is a Medicare Advantage plan.
Are there other deductibles for specific services?	Yes. Dental Benefits - \$100 each calendar year. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. This is a Medicare Advantage plan.
What is the out-of-pocket limit for this plan ?	Medical: \$1,000/individual	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Chiropractic benefits, Smoking Cessation benefits, out-of-network charges in excess of plan allowances, premiums , balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Not Applicable	This plan does not use a provider network . You can receive covered services from any provider .
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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	-----none-----
	<u>Specialist</u> visit	No charge	Not covered	-----none-----
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	-----none-----
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	-----none-----
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) 756-6756.	Generic <u>drugs</u>	\$10 <u>copayment</u> /prescription		Retail is up to 30-day supply. Mail Order is 90-day supply.
	Formulary brand <u>drugs</u> Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .	\$38 <u>copayment</u> /prescription		<u>Specialty drugs</u> are included at the applicable <u>copayment level</u> .
	Non-formulary brand <u>drugs</u>	\$63 <u>copayment</u> /prescription		If generic equivalent is available; you will be required to pay the price difference between the generic <u>drug</u> and the formulary brand name <u>drug</u> unless prescription notes "dispense

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)	
				as written.” The difference that you pay will not apply to the annual <u>out-of-pocket limit</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	-----none-----
	Physician/surgeon fees	No charge	Not covered	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	\$65 <u>copayment</u> /visit	Not covered	\$65 <u>copayment</u> waived if the patient is admitted to the hospital or if the reason for the visit to the emergency room is due to an accidental injury or life-threatening injury or sickness.
	<u>Emergency medical transportation</u>	No charge	Not covered	-----none-----
	<u>Urgent care</u>	No charge	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to the Medicare Allowed Amount per Medicare benefit period, 100% of charges once Medicare is exhausted.	Not covered	-----none-----
	Physician/surgeon fees		Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	-----none-----
	Inpatient services	No charge	Not covered	-----none-----
If you are pregnant	Office visits	No charge	Not covered	-----none-----

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 need help recovering or have other special health needs	Childbirth/delivery professional services	No charge	Not covered	-----none-----
	Childbirth/delivery facility services	No charge	Not covered	-----none-----
	<u>Home health care</u>	No charge	Not covered	-----none-----
	<u>Rehabilitation services</u>	No charge	Not covered	-----none-----
	<u>Habilitation services</u>	No charge	Not covered	-----none-----
	<u>Skilled nursing care</u>	No charge for the first 100 days. 100% of charges for day 101 and beyond.	Not covered	-----none-----
	<u>Durable medical equipment</u>	No charge	Not covered	-----none-----
If your child needs dental or eye care	<u>Hospice services</u>	No charge	Not covered	-----none-----
	Children's eye exam	No coverage.		No coverage under Medicare Supplement Plan, but coverage under Active Plan. See Active SBC.
	Children's glasses	No coverage.		No coverage under Medicare Supplement Plan, but coverage under Active Plan. See Active SBC.
	Children's dental check-up	No coverage.		No coverage under Medicare Supplement Plan, but coverage under Active Plan. See Active SBC.

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 • Cosmetic surgery (unless <u>Medically Necessary</u>) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. (see www.bcbsglobalcare.com) • Routine foot care • Weight loss programs (ESI weight loss program only)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan document</u> .)	
• Bariatric surgery (if <u>Plan</u> guidelines are met) • Chiropractic care	• Dental care (adult) • Hearing aids • Private-duty nursing (if <u>Plan</u> guidelines are met) • Routine eye care (adult)

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](#). For more information about the [Marketplace](#), 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

[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:

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 \$0¹
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments ²	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$70

¹ Assumes member is using a Medicare provider.

² [Copayments](#) apply to prescriptions.

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$0¹
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$5,300
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments ²	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$320

¹ Assumes member is using a Medicare provider.

² [Copayments](#) apply to prescriptions.

Mia's Simple Fracture

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

- The plan's overall deductible \$0¹
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$0
Copayments	\$70
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$70

¹ Assumes member is using a Medicare provider.

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

 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other underlined terms see the Glossary at https://www.healthcare.gov/sbc-glossary/ or call (800) 700-6756 to request a copy.		
Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$500/individual or \$1,250/family Certain <u>out-of-network claims</u> are treated as <u>in-network claims</u> as required by No Surprises Act.	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> unless 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>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. 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/ .
Are there other deductibles for specific services?	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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: \$5,000/individual or \$10,000/family Prescription: \$4,450/individual or \$8,900/family Certain <u>out-of-network claims</u> are treated as <u>in-network claims</u> as required by No Surprises Act.	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.
What is not included in the <u>out-of-pocket limit</u> ?	Chiropractic benefits, Smoking Cessation benefits, Teladoc Doctor Visit, <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> .
Will you pay less if you use a <u>network provider</u> ?	Yes*. See www. ibxtpa.com or call (833) 242-3330 for a list of <u>network providers</u> . * <u>Out-of-Network providers</u> may be treated as <u>In-Network providers</u> as required by No Surprises Act.	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 <u>referral</u> to see a <u>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 office</u> or clinic	Primary care visit to treat an injury or illness	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Teladoc – no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . Teladoc is an <u>In-Network Benefit</u> only – no coverage for any telemedicine program other than Teladoc. -----none-----
	<u>Specialist</u> visit			
	<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)			

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 need drugs to treat your illness or condition For more information about prescription drug coverage contact the Fund Office at (800) 700-6756.	Generic drugs	Retail - \$20 copayment /prescription (for 1 st 3 fills of same drug); 100% up to \$100 copayment /prescription (for 4 th or more fills of same drug) Smart 90 - \$50 copayment /prescription Mail Order - \$50 copayment /prescription	Not covered	Maintenance drugs must be filled through the Smart 90 Retail or Mail Order Program. Retail is up to 90-day supply. Mail Order is up to 90-day supply. 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 out-of-pocket limit. Clinical programs for some classes of drugs include prior authorization, step therapy, and/or quantity limits. Certain weight loss drugs may be covered.
	Formulary brand drugs	Retail - \$40 copayment /prescription (for 1 st 3 fills of same drug); 100% up to \$100 copayment /prescription (for 4 th or more fills of same drug) Smart 90 - \$100 copayment /prescription Mail Order - \$100 copayment /prescription		
	Non-formulary brand drugs	Retail - \$80 copayment /prescription (for 1 st 3 fills of same drug); 100% up to \$100 copayment /prescription (for 4 th or more fills of same drug) Smart 90 - \$200 copayment /prescription Mail Order - \$200 copayment /prescription		
	Specialty drugs	25% up to \$200		

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 unless otherwise required by No Surprises Act	-----none-----
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	25% coinsurance after \$250 copayment/visit	40% coinsurance of the Recognized Amount after \$250 copayment/visit unless otherwise required by No Surprises Act	\$250 copayment waived if the patient is admitted to the hospital or if the reason for the visit to the emergency room is due to an accidental injury or life-threatening condition.
	Emergency medical transportation	25% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	-----none-----
	Urgent care	25% coinsurance after \$75 copayment/visit	40% coinsurance after \$75 copayment/visit unless otherwise required by No Surprises Act	Teladoc – no copayment , deductible or coinsurance . Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate.
	Physician/surgeon fees			-----none-----

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 need mental health, behavioral health, or substance abuse services	Outpatient services		Mental Health – 40% coinsurance Substance Abuse – 50% coinsurance unless otherwise required by No Surprises Act	Teladoc – no copayment , deductible or coinsurance . Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Anthem Teladoc. Care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a license social worker.
	Inpatient services	25% coinsurance	Mental Health – 40% coinsurance unless otherwise required by No Surprises Act Substance Abuse – Residential Treatment Facility– not covered Substance Abuse Facility– 50% coinsurance unless otherwise required by No Surprises Act	The Hospital must be a licensed facility specializing in the treatment of mental or nervous disorders or substance abuse, as applicable. Care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a licensed social worker
If you are pregnant	Office visits			Maternity care may include tests and services described elsewhere in this document (i.e., ultrasound). Cost sharing does not apply to preventive services . Depending on the type of services, coinsurance or a deductible may apply. Pregnancy of a dependent child not covered.
	Childbirth/delivery professional services	25% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Pregnancy of a dependent child not covered. 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.
	Childbirth/delivery facility services			Pregnancy of a dependent child not covered.

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 need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	Must be homebound
	<u>Rehabilitation services</u>	Not covered	Not covered	-----none-----
	<u>Habilitation services</u>	Not covered	Not covered	-----none-----
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	Not covered	Limit 60 days per calendar year. <u>In-network</u> benefit only.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	<u>Hospice services</u>			
	Children's eye exam	No charge for children up to age 19		Limited to once every 12 months.
	Children's glasses	No charge for <u>medically necessary</u> services for children up to age 19		Limited to once every 24 months.
	Children's dental check-up	No charge for preventive services up to age 19		Cleanings and exams limited to two per year. Preventive dental services are not subject to dental <u>deductible</u> .

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 <u>excluded services</u> .)	
• Acupuncture • Cosmetic surgery (unless <u>Medically Necessary</u>) • <u>Habilitation services</u> • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. (see www.bcbsglobalcare.com) • Routine foot care • Weight loss programs (ESI weight management program only)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery (if Plan guidelines are met) • Chiropractic care (daily limit of \$30)	• Dental care (adult) • Hearing aids • Private-duty nursing (if Plan guidelines are met) • Routine eye care (adult)

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](#). For more information about the [Marketplace](#), 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.

[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:

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	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,570

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

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

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

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

The plan would be responsible for the other costs of these EXAMPLE covered services.

**Indiana / Kentucky / Ohio Regional
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