Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers and What it Costs

Coverage for: Employees & Dependents | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling **1-800-700-6756**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** indiv./**$1,250** family. Doesn't apply to In-Network Preventive Care or Dental Preventive Care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Dental Benefit - **$100** every 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.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** indiv./**$10,000** family.	The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Deductible**, chiropractic benefits, smoking cessation benefits, premiums, out of network charges above the plan allowance, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, call Anthem at **1-800-810-2583.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-700-6756**.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call **1-800-700-6756** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Out of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	40% coinsurance	----------none----------
	Specialist visit	25% coinsurance	40% coinsurance	----------none----------
	Other practitioner office visit	25% coinsurance	40% coinsurance	Chiropractic care: Maximum - $30 per visit; 25 visits per Calendar Year.
	Preventive care/screening/immunization	No Charge	40% coinsurance	In-Network Providers not subject to **deductible**. In-Network benefits at no charge include: Routine Physical Exam, Gynecological Exam, PSA Test, Mammogram – One each per Calendar Year; Routine Colonoscopy – One exam every 5 years; Well Child Exam & Immunizations (birth though age 24 months); and Routine Adult and Childhood Immunizations (age 2 and over).
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	25% coinsurance	40% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Out of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling the Fund Office at **1-800-700-6756** or Express Scripts at **1-800-867-4518.**	Generic drugs	Retail – $10 (for 1st 3 fills of same drug); 100% up to $100 (for 4th or more fills of same drug) Mail Order - $17.50 (up to 90-day supply)	Not Covered	----------none----------
	Single Source brand drugs	Retail – $38 (for 1st 3 fills of same drug); 100% up to $100 (for 4th or more fills of same drug) Mail Order - $95 (up to 90-day supply)	Not Covered	For Brand Name prescription drugs the Fund will only pay what it would have paid for the medically-equivalent generic unless prescription notes "dispense as written."
	Multiple Source brand drugs	Retail – $63 (for 1st 3 fills of same drug); 100% up to $100 (for 4th or more fills of same drug) Mail Order - $159 (up to 90-day supply)	Not Covered	For Brand Name prescription drugs the Fund will only pay what it would have paid for the medically-equivalent generic unless prescription notes "dispense as written."
	Specialty drugs	Retail – $63 (for 1st 3 fills of same drug); 100% up to $100 (for 4th or more fills of same drug) Mail Order - $159 (up to 90-day supply)	Not Covered	For Brand Name prescription drugs the Fund will only pay what it would have paid for the medically-equivalent generic unless prescription notes "dispense as written."

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Out of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees	25% coinsurance	40% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	25% coinsurance	40% coinsurance	----------none----------
	Emergency medical transportation	25% coinsurance	40% coinsurance	----------none----------
	Urgent care	25% coinsurance	40% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	40% coinsurance	Semiprivate room charge. Private room will be paid at the average Semiprivate room rate.
	Physician/surgeon fee	25% coinsurance	40% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% coinsurance	40% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	25% coinsurance	40% coinsurance	----------none----------
	Substance use disorder outpatient services	25% coinsurance	50% coinsurance	----------none----------
	Substance use disorder inpatient services	25% coinsurance	50% coinsurance	----------none----------
If you are pregnant	Prenatal and postnatal care	25% coinsurance	40% coinsurance	No coverage for dependent children
	Delivery and all inpatient services	25% coinsurance	40% coinsurance	No coverage for dependent children
If you need help recovering or have other special health needs	Home health care	25% coinsurance	40% coinsurance	Must be homebound
	Rehabilitation services	25% coinsurance	40% coinsurance	----------none----------
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	25% coinsurance	40% coinsurance	For rehabilitation services only
	Durable medical equipment	25% coinsurance	40% coinsurance	----------none----------
	Hospice service	25% coinsurance	40% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Out of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care More information about **vision coverage** is available by calling the Fund Office at **1-800-700-6756** or VSP at **1-800-877-7195.** More information about Dental coverage is available by calling the Fund Office at **1-800-700-6756** or Delta Dental at **1-800-524-0149.**	Eye exam	No Charge after $10 copay	No Charge up to $45	Limited to once every 12 months.
	Glasses	Frames – No Charge up to $120 after $15 copay, then 20% discount. Lenses – No Charge (no separate copay; included in Frames copay)	Frames – No Charge up to $70. Lenses–No Charge up to: $30 - Single $50 - Bifocal $65 - Trifocal $100 - Lenticular	Limited to once every 24 months.
	Dental check-up	No Charge	No Charge up to the out of network allowed amount	Preventive Services are not subject to **deductible**.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery (unless medically necessary)
- Habilitation services
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (see Plan for limitations)
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Private duty nursing (See Plan for limitations)
- Routine eye care (Adult)

SPECIAL NOTICE FOR MEDICARE-ELIGIBLE EMPLOYEES: The benefits provided under the plan through the Humana Medicare Advantage Plan pay only if you are enrolled in Medicare both Parts A and B.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-700-6756. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Fund Office at 1-800-700-6756 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,180
- **Patient pays** $2,360

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$1,690
Limits or exclusions	$150
Total	**$2,360**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,890
- **Patient pays** $1,510

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$380
Coinsurance	$550
Limits or exclusions	$80
Total	**$1,510**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.