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

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

October 2018

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.

Coverage Period: 01/01/2019 – 12/31/2019

Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund: Actives and Retirees

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

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?	$500/individual or $1,250/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network Preventive Care and Dental Preventive Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
What is the out-of-pocket limit for this plan?	Medical: $5,000/individual or $10,000/family Prescription: $2,900/individual or $5,800/family	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, LiveHealth Online Doctor Visit, deductibles, 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?	Yes. Call (800) 810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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 provider's office or clinic	Primary care visit to treat an injury or illness	25% coinsurance	40% coinsurance	Anthem LiveHealth Online – no copayment, deductible or coinsurance. Anthem LiveHealth Online is an In-Network Benefit only – no coverage for any telemedicine program other than Anthem LiveHealth Online.
	Specialist visit			----------none----------
	Preventive care/screening/ immunization	No charge	40% coinsurance	In-network providers not subject to the deductible. Plan covers preventive services and supplies required by ACA. Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	40% coinsurance	----------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) 392-8726.	Generic drugs	Retail - $20 (for 1st 3 fills of same drug); 100% up to $100 (for 4th or more fills of same drug) Mail Order - $50	Not covered	Retail is up to 30-day supply. Mail Order is 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.
	Formulary brand drugs	Retail - $40 (for 1st 3 fills of same drug); 100% up to $100 (for 4th or more fills of same drug) Mail Order - $100		
	Non-formulary brand drugs	Retail - $80 (for 1st 3 fills of same drug); 100% up to $100 (for 4th or more fills of same drug) Mail Order –$200		
	Specialty drugs	Retail - 25% up to $200		
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 – no copayment, 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----------

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	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.
	Durable medical equipment	25% coinsurance	40% coinsurance	----------none----------
	Hospice services			
If your child needs dental or eye care	Children's eye exam	No charge after $10 copayment	No charge up to $45	Limited to once every 12 months.
	Children's glasses	Frames – No charge up to $120 after $15 copayment, then 20% discount. Lenses – No charge; (no separate copayment included in Frames copayment	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 out-of-network allowed	Preventive dental services are not subject to dental deductible.

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.)		
• 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 (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	• 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
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.

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

In this example, Peg would pay:

Cost Sharing	
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

In this example, Joe would pay:

Cost Sharing	
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

In this example, Mia would pay:

Cost Sharing	
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.