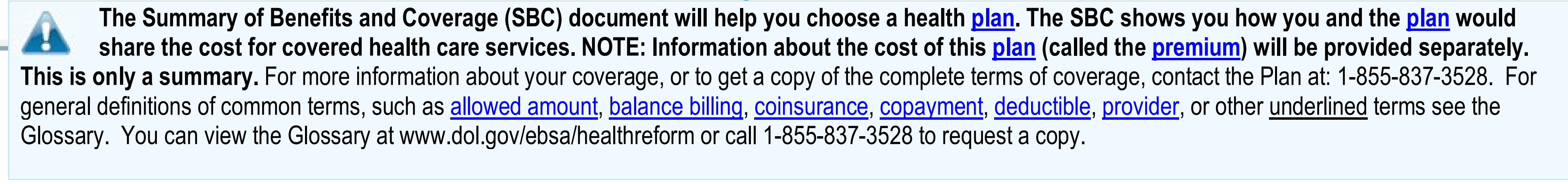
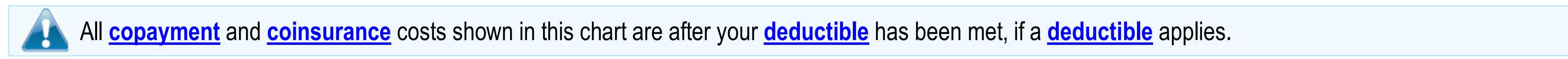
# Ohio Carpenters' Heath Plan: Plan 2 – Medicare-Advantage UHC

**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, contact the Plan at: 1-855-837-3528. 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 www.dol.gov/ebsa/healthreform or call 1-855-837-3528 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. $200 or $325 (depending on your home local) for prescription benefits. 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?** | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. This is a Medicare Advantage plan. |
| **What is not included in the out-of-pocket limit?** | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. This is a Medicare Advantage plan. |
| **Will you pay less if you use a network provider?** | No. | This plan does not use a provider network. You can receive covered services from any provider that accepts Medicare and willing to bill the plan |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. This is a Medicare Advantage plan. |



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 |
|---|---|---|---|---|
| | | Your Cost If You Use a Medicare Provider | Your Cost If You Do Not Use a Medicare Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No charge | Not covered | ------------------------None------------------------ |
| | Specialist visit | No charge | Not covered | ------------------------None------------------------ |
| | Preventive care/screening/ immunization | No charge | Not covered | ------------------------None------------------------ |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | Not covered | ------------------------None------------------------ |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | ------------------------None------------------------ |

| Common Medical Event | Services You May Need | Employer Group Waiver Plan (EGWP) ($200 deductible) | Limitations & Exceptions |
|---|---|---|---|
| If you need drugs to treat your illness or condition<br><br>More information about prescription drug coverage is available by calling (866) 685-2792. | Generic | $10 copay | Dollar amounts shown are for prescriptions filled at a pharmacy for a 31-day supply. Certain over-the-counter medications and supplements covered with a prescription. Immunizations are available at pharmacy.<br><br>Some drugs are available in a 90-day supply from pharmacies for a higher cost per prescription. Mail-order is also available for a 90-day supply of maintenance drugs. Mail-order copays are less than 90-day pharmacy copays.<br><br>This is a summary of your benefits. Please call 855-837-3528 for additional information, including Medicare coverage requirements. |
| | Preferred brand drugs | $30 copay | |
| | Non-preferred brand drugs | $75 copay | |
| | Specialty drugs | $100 copay | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Your Cost If You Use a Medicare Provider | Your Cost If You Do Not Use a Medicare Provider | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | -----------------------None----------------------- |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room care | No charge | Not covered | -----------------------None----------------------- |
| | Emergency medical transportation | No charge | Not covered | -----------------------None----------------------- |
| | Urgent care | 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 | | | |
| **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----------------------- |
| | Childbirth/delivery professional services | No charge | Not covered | -----------------------None----------------------- |
| | Childbirth/delivery facility services | No charge | Not covered | -----------------------None----------------------- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Your Cost If You Use a Medicare Provider | Your Cost If You Do Not Use a Medicare Provider | |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | -----------------------None----------------------- |
| | Rehabilitation services (Physical Therapy) | No charge | Not covered | -----------------------None----------------------- |
| | Habilitation services (Occupational and Speech Therapy) | No charge | Not covered | -----------------------None----------------------- |
| | Skilled nursing care | No charge for the first 100 days. 100% of charges for day 101 or beyond | Not covered | -----------------------None----------------------- |
| | Durable medical equipment | No charge | Not covered | -----------------------None----------------------- |
| | Hospice services | No charge | Not covered | -----------------------None----------------------- |
| If your child needs dental or eye care | Children's eye exam | No charge for child to age 19. | | Adult (over age 19) coverage not available. |
| | Children's glasses | No charge for child to age 19 for medically necessary glasses. | | Adult (over age 19) coverage not available. |
| | Children's dental check-up | No charge for child to age 19 for preventive care; no annual maximum for medically necessary treatment. | | Adult (over age 19) coverage not available. |

## 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 and limitations of coverage.) | | |
|---|---|---|
| • Acupuncture<br>• Bariatric Surgery<br>• Cosmetic Surgery | • Infertility Treatment<br>• Long-term Care | • Weight Loss Programs |

| Other Covered Services (Limitations may apply to these and other covered services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Chiropractic Care<br>• Hearing Aid | • Non-emergency care when travelling outside the U.S. for no more than 30 days | • Private-duty Nursing<br>• Routine Foot Care |

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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 1-800-318-2596.

**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 Plan at 855-837-3528 or EBSA at 1-866-444-3272 or www.dol.gov/ebsa. Additionally, a consumer assistance program can help you file your appeal. Contact: Ohio Department of Insurance at (800) 686-1526 or www.insurance.ohio.gov/Pages/default.aspx.

### Does this plan provide Minimum Essential Coverage?

Yes. 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 plan meet the Minimum Value Standards?

Yes. 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.**

### Language Access Services:

Para obtener asistencia en Español, llame al (855) 837-3528.

*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** — $0[1]
- **Specialist copayment** — $0
- **Hospital (facility) coinsurance** — 0%
- **Other** — 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** | **$12,840** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles[2] | $40 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions[2] | $60 |
| **The total Peg would pay is** | **$100** |

[1] Assumes member is using a Medicare provider.
[2] Costs are for prescription or over-the-counter drugs.

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** — $0[1]
- **Specialist copayment** — $0
- **Hospital (facility) coinsurance** — 0%
- **Other** — 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** | **$7,460** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles[2] | $300 |
| Copayments[2] | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions[2] | $60 |
| **The total Joe would pay is** | **$600** |

[1] Assumes member is using a Medicare provider.
[2] Costs are for prescription or over-the-counter drugs.

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** — $0[1]
- **Specialist copayment** — $0
- **Hospital (facility) coinsurance** — 0%
- **Other** — 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** | **$2,010** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

1. [1] Assumes member is using a Medicare provider.

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