Ohio Carpenters' Heath Plan: Plan 2 – Medicare-Eligible Retiree: Supplement

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.

THIS PLAN ONLY PAYS BENEFITS SUPPLEMENTAL TO MEDICARE. IT DOES NOT COVER SERVICES NOT COVERED ON A PRIMARY BASIS BY MEDICARE. IF MEDICARE IS NOT TIMELY OBTAINED, THIS PLAN WILL NOT COVER EXPENSES THAT WOULD HAVE BEEN PAID BY MEDICARE. SEE PAGE 8.

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 supplemental plan. See page 8.
Are there services covered before you meet your deductible?	Not Applicable	This plan does not have a deductible. This is a Medicare supplemental plan. See page 8.
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 supplemental plan. See page 8.
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 supplemental plan. See page 8.
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 supplemental plan. See page 8.
Will you pay less if you use a network provider?	Yes. Medicare-approved providers are **network providers**	If you do not use a Medicare approved provider, benefits will only be paid up to the amount that would have been paid had a Medicare approved provider been used. However, you must have Medicare coverage to obtain any benefits whether or not you use a Medicare approved provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral. This is a Medicare supplemental plan. See page 8.

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	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Specialist visit	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Preventive care/screening/ immunization	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Imaging (CT/PET scans, MRIs)	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.

Common Medical Event	Services You May Need	Prescription Drug Plan (PDP) ($325 deductible)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling (866) 685-2792.	Generic	$4 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. 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. This is a summary of your benefits. Please call 855-837-3528 for additional information, including Medicare coverage requirements.
	Preferred brand drugs	$6-$8 copay	
	Non-preferred brand drugs	25% coinsurance	
	Specialty drugs	27-50% coinsurance	

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	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Emergency medical transportation	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Urgent care	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
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	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Inpatient services	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
If you are pregnant	Office visits	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Childbirth/delivery professional services	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.

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 are pregnant	Childbirth/delivery facility services	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
If you need help recovering or have other special health needs	Home health care	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Rehabilitation services (Physical Therapy)	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Habilitation services (Occupational and Speech Therapy)	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Skilled nursing care	No charge for the first 100 days. 100% of charges for day 101 or beyond	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Durable medical equipment	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
	Hospice services	No charge	100% of charges above the Medicare Allowed Amount	This Plan pays supplemental to Medicare only.
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
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aid
- Infertility Treatment
- Long-term Care
- Routine Foot 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
- Non-emergency care when travelling outside the U.S. for no more than 30 days
- Private-duty Nursing

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	$60
The total Peg would pay is	**$100**

[1] Assumes member is using a Medicare provider.
[2] Deductible applies 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	$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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$600**

[1] Assumes member is using a Medicare provider.
[2] Deductible applies to prescriptions.

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.

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Part A Supplemental Benefits – Inpatient Benefits for Medicare covered services received in a Medicare approved facility:

- Part A deductible for the first 60 days of Hospital care per Medicare Benefit Period.
- The Part A coinsurance for the 61st through the 90th day of Hospital care per Medicare Benefit Period.
- The Part A coinsurance for lifetime reserve days.
- The first three pints of blood that you receive each calendar year.
- Part A coinsurance for hospice care services and home health care services.
- Part A coinsurance for the 21st through the 100th day of care in a Skilled Nursing Facility.

Part B Supplemental Benefits – Outpatient Benefits

- Part B deductible (except deductible on pints of blood, see below).
- Part B blood deductible for the first three pints of blood each calendar year.
- Part B coinsurance.