Ohio Carpenters' Fringe Benefit Funds

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June 2024

IMPORTANT NOTICE – SHOP PLAN ELECTION FORM:

SPECIAL OPEN ENROLLEMENT

Dear Plan Participant:

This notice contains important information about coverage as a participant in the Ohio Carpenters' Health Plan (Plan). Please read this notice carefully.

As a participant in the Shop plan, you can change your coverage once per year in December, but we are opening a special one-time enrollment mid-year due to the rate changes set forth to occur on July 1, 2024. **If you would like to change your current coverage option, you must complete the enclosed election form and return it to the Fund Office by June 25, 2024. If you do not, your current coverage will remain the same through 2024.**

Shop Election Form

Enclosed please find the election form which will allow you to make changes to your coverage effective July 1, 2024. The election form breaks down the cost of coverage for the Full Plan the Shop Plan. The coverage details for each plan are included in this mailing as the Summary of Benefits and Coverage.

Shop Employees can elect one of the following options:

- Coverage under the SHOP PLAN (Plan 2), at a cost of $500 per month single or $850 per month family.
- Coverage under the FULL PLAN (Plan 1), at a cost of $1,150.00 per month (same cost single or family)

Important Note: Out of pocket costs for participants are higher under the Shop Plan, and there is NO COVERAGE for prescription drugs, dental, hearing, vision, or Medical Reimbursement Account, which is why it costs less than the Full Plan.

Please complete the election form and return it to the Fund Office at the address on the form on or before June 25, 2024. IF THIS FORM IS NOT TIMELY RETURNED, for 2024 YOUR COVERAGE WILL REMAIN THE SAME.

Summary of Benefits and Coverage

Enclosed please find the Summary of Benefits and Coverage ("SBC") for both the Full and Shop plans, 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

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 covered services, such as office visits, prescription drugs, and emergency room services.

Coverage Examples/Questions and Answers

The coverage examples on the last two pages 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. These are examples only. They should not be used to estimate your actual costs under the Plan.

If you have any questions regarding the content of this notice, or your coverage in general, please contact the Fund Office at (248) 641-4967 or Toll Free (855) 837-3528.

OHIO CARPENTERS' HEALTH PLAN
P.O BOX 1257
TROY, MI 48099-1257
(248) 641-4967
(855) 837-3528

ELECTION FORM – SHOP

Rates Effective 7/1/2024

MEDICAL BENEFITS (choose only one):

	Single Coverage	Family Coverage
SHOP PLAN	**$500.00 _____**	**$850.00 _____**
FULL PLAN	**$1,150.00 _____**	**$1,150.00 _____**

By signing this form, I acknowledge that I have reviewed the enclosed information. I also understand that regardless of my election, the Plan encourages participants to use providers (doctors, hospitals, etc.) that participate in the Fund's network, and this will result in lower out of pocket costs to me and my family. I also understand that my election cannot be changed until the next calendar year unless I have a qualifying event, such as marriage or a new dependent.

Participant's Name: _____
(Print)

Participant's Signature: _____

Participant's Social Security #: _____

Date: _____

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 (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 https://www.healthcare.gov/sbc-glossary/ or call (855) 837-3528 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network*: $500/individual or $1,000/family Out-of-Network: $1,000/individual or $2,000/family **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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 unless 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?	In-Network Wellness & Preventive Services, Teladoc Doctor Visit, Prescription Drugs, PPO or Premier Dental Services and Vision Benefits 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. For example, this plan covers certain in-network 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/.
Are there other deductibles for specific services?	Yes. For Non-Participating Dentists, the deductible is: $50/individual or $100/family	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.
What is the out-of-pocket limit for this plan?	**Medical:** In-Network*: $3,500/individual or $7,000/family. Unlimited for Out-of-Network **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.* **Prescription:** $5,600/individual or $11,200/family Unlimited for Out-of-Network.	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?	Premiums, balance billing charges, non-network cost sharing, health care this plan doesn't cover, charges in excess of reasonable and customary and penalties for failing to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes*. See www. ibxtpa.com or call (833) 242-3330 for a list of network providers. **Out-of-Network providers* may be treated as In-Network providers as required by No Surprises Act.*	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	$20 copayment/visit	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan	In-network not subject to deductible. Teladoc Program - no copayment, deductible or coinsurance. Teladoc s an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
	Specialist visit	$40 copayment/visit		In-network not subject to deductible.
	Preventive care/screening/ Immunization	No charge	Not covered	Coverage available in-network only. Immunizations available from any allowed providers, including pharmacies. 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 after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan	----------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 More information about **prescription drug coverage** is available by calling Express Scripts at (866) 685-2792.	Generic drugs	Retail – $20 copayment/ prescription Smart 90 - $50 copayment/prescription Mail Order – $50 copayment/prescription	Retail – $20 copayment/ prescription, plus any amount above reasonable and customary charges Mail Order – Not covered	No deductible on Prescription Benefits. Copayments do not apply to deductible. Retail (30-day supply) – Participant pays the applicable copayment at a network provider retail pharmacy using their Express Scripts card. If the Participant uses an out-of-network provider or does not use their Express Scripts card, the Participant pays 100% up front at retail pharmacy and then mails the claim form to the Fund Office for reimbursement (less the copayment plus amount above reasonable and customary charges). Mail Order (90-day supply) – Participant pays only copayment. Mail Order prescriptions can be obtained only through the Express Scripts Mail Order Service or the Smart 90 Retail or Mail Order Program. Precertification is required for specialty drugs and some injections. Clinical programs for some classes of drugs include: prior authorization, step therapy, and/or quantity limits. Certain over-the-counter medications and supplements covered with a prescription. Immunizations are available at a pharmacy. Maintenance medications may be filled at retail for the first 3 30-day fills. After that, they must be filled by through the Smart 90 Retail or Mail Order Program or the Express Scripts Mail Order Service.
	Formulary brand drugs	Retail – $40 copayment/ prescription Smart 90 - $100 copayment/prescription Mail Order – $100 copayment/prescription	Retail – $40 copayment/ prescription, plus any amount above reasonable and customary charges Mail Order – Not covered	
	Non-formulary brand drugs	Retail – $80 copayment/ prescription Smart 90 - $200 copayment/prescription Mail Order – $200 copayment/prescription	Retail – $80 copayment/ prescription, plus any amount above reasonable and customary charges Mail Order – Not covered	
	Specialty drugs	Retail – 25% not to exceed a maximum of $200 copayment/ prescription Mail Order – Not covered	Retail – 25% to a maximum of $200 copayment/prescription, plus any amount above reasonable and customary charges Mail Order – 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan unless otherwise required by No Surprises Act	----------none----------
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$250 copayment/visit, then 25% coinsurance after the deductible	$250 copayment/visit, then 25% of the Recognized Amount unless otherwise required by No Surprises Act	Copayment waived if patient is admitted to the hospital or if visit is due to an accidental or life-threatening event.
	Emergency medical transportation	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible unless otherwise required by No Surprises Act	----------none----------
	Urgent care	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible unless otherwise required by No Surprises Act	In-network not subject to deductible. Teladoc Program - no copayment, deductible or coinsurance. Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan. unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate. Precertification required.
	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	In office physician visit: subject to $20 copayment/visit only 25% coinsurance after the deductible for all other outpatient services	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan unless otherwise required by No Surprises Act	In-network in office physician visit not subject to deductible. Teladoc Program – no copayment, deductible or coinsurance. Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
	Inpatient services	25% coinsurance after the deductible		Residential Treatment Facility must be an in-network facility and is limited to 60 days per calendar year. Precertification required.
If you are pregnant	Office visits	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan unless otherwise required by No Surprises Act	Maternity care may include tests and services described elsewhere in this document (i.e., ultrasound). Maternity care of a dependent child is covered. Newborn care of a newborn of a dependent child is not covered. Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or a deductible may apply.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			In-patient stay of at least 48 hours (vaginal delivery) or at least 96 hours (cesarean section delivery). Maternity care of a dependent child is covered. Newborn care of a newborn of a dependent child is 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	Home health care	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan	Coverage is limited to 40 days max per year combined In and out-of-network providers.
	Rehabilitation services			Limit 70 combined visits per year combined In and out-of-network providers for combined Occupational, Physical and Speech Restorative Visits.
	Habilitation services			
	Skilled nursing care		Not covered	Limit 60 days per calendar year. In-network benefit only.
	Durable medical equipment		45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan	Includes rental fees not to exceed the purchase price. Must meet medically necessary requirements.
	Hospice services			Services can be provided through a freestanding hospice facility or a hospice program sponsored by a hospital or home health care agency or at a private residence.
If your child needs dental or eye care	Children's eye exam	No charge for children up to age 19		Limited to once every 12 months.
	Children's glasses	No charge for medically necessary 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 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 and limitations of coverage.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Routine foot care

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 (limit of 25 visits/year)
- Dental care (adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S. (see www.bcbsglobalcore.com)
- Private-duty nursing
- Routine eye care (adult)
- Weight loss program (ESI weight management program only)

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 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 Fund Office at (855) 837-3528 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 (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	$500
Specialist copayment	$40
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$3,000
What isn't covered	
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 copayment	$40
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	
Specialist copayment	$40
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$400
What isn't covered	
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.

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 (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 https://www.healthcare.gov/sbc-glossary/ or call (855) 837-3528 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network*: $1,750/individual / $3,500/family Out-of-Network: $3,500/individual / $7,000/family **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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 unless 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?	In-Network Wellness & Preventive Services and Teladoc Doctor Visit 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. For example, this plan covers certain in-network 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/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network*: – $7,350/individual / $14,700/family Out-of-Network: $10,000/individual / $20,000/family **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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?	Premiums, balance billing charges, non-network cost sharing, health care this plan doesn't cover, charges in excess of reasonable and customary and penalties for failing to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes*. See www.ibxtpa.com or call (833) 242-3330 for a list of network providers. **Out-of-Network providers* may be treated as In-Network providers as required by No Surprises Act.*	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	$20 copayment/visit	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan	In-network not subject to deductible. Teladoc Program - no copayment, deductible or coinsurance. Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
	Specialist visit	$40 copayment/visit		In-network not subject to deductible.
	Preventive care/screening/ Immunization	No charge	Not covered	Coverage available in-network only. Immunizations available from any allowed providers, including pharmacies. 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.

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 a test	Diagnostic test (x-ray, blood work)	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan	----------none----------
	Imaging (CT/PET scans, MRIs)			
-If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling Express Scripts at (866) 685-2792.	Generic drugs	Not covered		----------none----------
	Formulary brand drugs			
	Non-formulary brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan unless otherwise required by No Surprises Act	----------none----------
	Physician/surgeon fees			

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 immediate medical attention	Emergency room care	$250 copayment/visit, then 25% coinsurance after the deductible	$250 copayment/visit, then 25% of the Recognized Amount unless otherwise required by No Surprises Act	Copayment waived if patient is admitted to the hospital or if visit is due to an injury or life-threatening event.
	Emergency medical transportation	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible unless otherwise required by No Surprises Act	----------none----------
	Urgent care	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible unless otherwise required by No Surprises Act	In-network not subject to deductible. Teladoc Program - no copayment, deductible or coinsurance. Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate. Precertification required.
	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	In office physician visit: subject to $20 copayment/visit only 25% coinsurance after the deductible for all other outpatient services.	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan unless otherwise required by No Surprises Act	In-network in office physician visit not subject to deductible. Teladoc Program – no copayment, deductible or coinsurance. Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
	Inpatient services	25% coinsurance after the deductible		Residential Treatment Facility must be an in-network facility and is limited to 60 days per calendar year. Precertification required.
If you are pregnant	Office visits	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan	Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). Maternity care of a dependent child is covered. Newborn care of a newborn of a dependent child is not covered. Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or a deductible may apply.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			In-patient stay of at least 48 hours (vaginal delivery) or at least 96 hours (cesarean section delivery). Maternity care of a dependent child is covered. Newborn care of a newborn of a dependent child is 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	Home health care	25% coinsurance after the deductible	45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan	Coverage is limited to 40 days max per year combined In and out-of-network providers.
	Rehabilitation services			Limit 70 combined visits per year combined In and out-of-network providers for combined Occupational, Physical and Speech Restorative Visits.
	Habilitation services			
	Skilled nursing care		Not covered	Limit 60 days per calendar year. In-network benefit only.
	Durable medical equipment		45% coinsurance based on reasonable and customary charges, after the deductible plus amounts billed by provider not paid by plan	Includes rental fees not to exceed the purchase price. Must meet medically necessary requirements.
	Hospice services			Services can be provided through a freestanding hospice facility or a hospice program sponsored by a hospital or home health care agency or at a private residence.
If your child needs dental or eye care	Children's eye exam	No charge for children up to age 19		Limited to once every 12 months.
	Children's glasses	No charge for medically necessary 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 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 and limitations of coverage.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Prescription drugs
- Routine eye care (adult)
- Routine foot care

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 traveling outside the U.S. (see www.bbcbsglobalcore.com)
- Private-duty nursing
- Weight loss programs (ESI weight management program only)

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 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 Fund Office at (855) 837-3528 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 (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	$1,750
Specialist copayment	$40
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$0
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$4,520**

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

The plan's overall deductible	$1,750
Specialist copayment	$40
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$4,600**

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

The plan's overall deductible	$1,750
Specialist copayment	
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,060**

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