Ohio Carpenters' Fringe Benefit Funds
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July 2023

To: **All Participants of the Ohio Carpenters Health Plan**

From: **Board of Trustees of the Ohio Carpenters Health Plan**

Please read this Notice carefully. It contains important information about changes to the Ohio Carpenters Health Plan (Plan). Please keep this notice with your Ohio Carpenters Health Fund Summary Plan Description (SPD). The changes set forth in this notice are effective January 1, 2023, unless otherwise indicated below.

1. OUT-OF-NETWORK RATE

As you know, effective January 1, 2023, Independence Blue Cross (Independence) replaced Anthem Blue Cross as your medical network provider, and medical claims are now paid by Independence Administrators (IA) instead of BeneSys. This notice clarifies how the Plan pays claims from out-of-network providers and facilities effective 1/1/23.

Prior to 1/1/23, the amount paid by the Plan for out-of-network claims was 55% of the amount determined to be "Reasonable and Customary." "Reasonable and Customary," in general, is the amount charged by most providers providing like services in the geographic area where the services are rendered.

As a result of the transition to Independence, out-of-network claims are now paid based on Medicare Rates instead of "Reasonable and Customary" amounts, as follows:

- For institutional procedures, the Plan will pay 55% of 150% of the applicable Medicare rate.
- For professional procedures, the Plan will pay 55% of 100% of the applicable Medicare rate.
- Where there is no Medicare rate available, the Plan will pay 55% of 50% of actual charges.

For example:

- The Plan receives an out of network charge of $1,000 for a non-emergency elective institutional procedure and the applicable Medicare Rate is $500. Assuming the deductible is met, the Plan will pay $412.50, calculated as follows: 55% multiplied by $750 (150% of $500.00) = $412.50.

- The participant is responsible to pay 40% of the approved charge, which is $337.50 (45% of $750).

- The participant may also be responsible for any additional balance billing assessed by the provider, which in this example would be another $250 - the original charge of $1,000 less $412.50 paid by the Plan and the $337.50 co-insurance paid by the participant leaves a $250 balance.

As seen in this example, any balance owed to an out-of-network provider after the Plan makes payment remains the participant's responsibility – this is known as balance billing (subject to exceptions, such as Emergencies for which you cannot be balance billed). **Therefore, we encourage you to use in-network providers to save costs for yourself and the Plan.**

2. EXPIRATION OF EXTENDED PLAN DEADLINES

Due to the National Emergency, beginning March 1, 2020, the deadlines below were extended until the earlier of either

(1) one year from the individual's original deadline as stated in the Plan; or (2) 60 days after the announced end of the National Emergency as declared by the President (referred to as the Outbreak Period). This deadline extension applied to these calculations:

- The COBRA election period;
- Timely payment of COBRA premiums;
- Timely notice from covered person of a COBRA qualifying event;
- Timely notice from the plan to a covered person that they may elect COBRA;
- Timely election of HIPAA Special Enrollment rights;
- Timely filing of claims;
- Timely filing of appeals; and
- Timely filing of requests for external review.

The National Emergency ended on May 11, 2023, and therefore the above extended deadlines will expire on July 10, 2023 (i.e., the end of the Outbreak Period mentioned above). Without these extended deadlines, the deadlines in the Plan will revert to those in place before the National Emergency, i.e. the Plan deadlines set forth in the Plan.

3. CHANGES TO APPEAL PROCESS EFFECTIVE JANUARY 1, 2023

Effective January 1, 2023, all appeals should be submitted directly to Independence Administrators at: Independence Administrators, Appeals Department, PO Box 21974, Eagan, MN 55121. You will soon be receiving a new Summary Plan Description detailing the Appeals Process.

4. COVERAGE FOR AUTISM SPECTRUM DISORDER (ASD) AND ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER (ADHD)

Effective January 1, 2023, the Plan will provide coverage for treatment and services related to ASD and ADHD. Please be advised that all exclusions listed in the Plan document still apply.

5. CHANGES TO ORTHODONTIC BENEFIT

Effective January 1, 2023, the lifetime treatment limit for Class IV orthodontics has increased from $1,000 to $1,500.

6. CHANGES TO CORONAVIRUS/COVID-19 BENEFITS EFFECTIVE MARCH 14, 2023

Effective March 14, 2023, the Plan changed how it covers treatment and testing of COVID-19.

COVID-19 TESTING

The Plan will no longer cover COVID-19 Testing at 100% for both in and out-of-network. Coverage for COVID-19 Testing is now covered as follows:

Medical Benefits	In-Network	Out-Of-Network
COVID-19 testing	75% after deductible	55% of Applicable Medicare Rate after deductible

TREATMENT OF COVID-19

Treatment of COVID-19 will no longer be covered In-Network at 100%. Treatment of COVID-19 is now covered as follows:

Medical Benefits	In-Network	Out-Of-Network
Treatment for COVID-19 (this does not include Long- or Post-COVID-19)	75% after deductible	55% of Applicable Medicare Care Rate after deductible

OTC COVID-19 TESTS

The Plan will continue to cover FDA approved OTC COVID-19 Tests purchased for person use (e.g., not for employment purposes or resale) through December 31, 2023 as follows:

Medical Benefits	In-Network	Out-Of-Network
OTC COVID-19 Testing – FDA approved tests purchased on or after January 15, 2022 through December 31, 2023, for personal use (e.g., not for employment purposes or resale) Maximum 8 tests per 30 day period per covered person Note: OTC COVID-19 tests covered via Pharmacy Benefit Manager.	100% coverage at retail and via direct to consumer shipping options provided by Pharmacy Benefit Manager	55% of Applicable Medicare Rate after deductible

OTC COVID-19 Tests purchased after December 31, 2023, will be covered via normal cost sharing as set forth in the Plan.

7. CHANGES TO EXCLUSION FOR GENDER DYSPHORIA

Currently, the Plan excludes coverage for "Transexual or Transgender surgery or any treatment leading to or in connection with transsexual or transgender surgery.

Effective June 30, 2023, the Plan's exclusion has been revised to exclude coverage for all services, items, conditions, or expenditures relating to "Gender Dysphoria (e.g. (e.g., transexual or transgender surgery, sex transformation, gender reassignment, and any treatment leading to or in connection with transsexual or transgender surgery). This exclusion includes all medications, implants, surgery, medical or psychiatric treatment, both pre- and post-operative care, and related hormone treatments.

8. CHANGES TO COVERAGE RELATING TO INFERTILITY

The Plan excludes coverage for "Artificial insemination, in vitro fertilization, embryo transfer procedures, or other procedures related to the treatment of infertility." However, the Fund currently covers procedures related to the diagnosis of infertility.

Effective November 29, 2022, the Fund will also cover genetic testing used to diagnose infertility.

9. IMPORTANT PHONE NUMBERS

As a reminder, here is a list of important phone numbers:

Medical Benefit Questions For Active Participants/Non-Medicare Retirees/Shop Employees:
Contact Independence Administrators (IA) at 1-833-242-3330.

Medical Benefit Questions For Retirees Enrolled in the Humana Medicare Advantage Plan:
Contact Labor First at 216-260-0988.

All Other Benefit Questions:
Contact BeneSys at 855-837-3528.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE FUND OFFICE AT (855) 837-3528.

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OHIO CARPENTERS'
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Important Fund Information