







## Ohio Carpenters' Fringe Benefit Funds

Health Fund: P.O. Box 1257, Troy, MI 48099

Pension and Annuity Funds: P.O. Box 31580, Independence, OH 44131

Phone: (248) 641-4967 Toll Free: (855) 837-3528

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December 2023

### **IMPORTANT NOTICE – SHOP PLAN ELECTION FORM AND SUMMARY OF BENEFITS AND COVERAGE**

Dear Plan Participant:

This notice contains important information regarding coverage as a participant in the Ohio Carpenters' Health Plan (Plan). Please read this notice carefully. As a participant in the Shop plan, you are entitled to change your Plan coverage once per year. Shop Employees have the option to select between the Full Plan and the Shop Plan, which has reduced benefits at a lower cost.

#### **Shop Election Form**

Enclosed please find the election form the 2024 calendar year. 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 the mailing as the Summary of Benefits and Coverage.

#### **Shop Employees will be able to elect one of the following options:**

- Coverage under the Shop Plan (Plan 2), at a cost of \$450 per month single or \$750 per month family.
- Coverage under the Full Plan (Plan 1), at a cost of \$950.00 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 December 30, 2023. **IF THIS FORM IS NOT RETURNED, for 2024, you will be enrolled in the same coverage you had for 2023.**

#### **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

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## **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. It is important to note that 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 1/1/2020

### MEDICAL BENEFITS (choose only one):

	<u>Single Coverage</u>	<u>Family Coverage</u>
SHOP PLAN	\$450.00 _____	\$750.00 _____
FULL PLAN	\$950.00 _____	\$950.00 _____

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:
<u>What is the overall deductible?</u>	<p><u>In-Network</u>*: \$1,750/individual / \$3,500/family  <u>Out-of-Network</u>: \$3,500/individual / \$7,000/family  *Certain <a href="#">out-of-network claims</a> are treated as <a href="#">in-network claims</a> as required by No Surprises Act.</p>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> unless the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<u>Are there services covered before you meet your deductible?</u>	<u>In-Network</u> Wellness & <a href="#">Preventive Services</a> and Teladoc Doctor Visit are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">in-network preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	<p><u>In-Network</u>*: – \$7,350/individual / \$14,700/family  <u>Out-of-Network</u>: \$10,000/individual / \$20,000/family  *Certain <a href="#">out-of-network claims</a> are treated as <a href="#">in-network claims</a> as required by No Surprises Act.</p>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<u>What is not included in the out-of-pocket limit?</u>	Premiums, <a href="#">balance billing</a> charges, <a href="#">non-network cost sharing</a> , health care this <a href="#">plan</a> doesn't cover, charges in excess of <a href="#">reasonable and customary</a> and penalties for failing to obtain <a href="#">preauthorization</a> for services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes*. See <a href="http://www.ibxtpa.com">www.ibxtpa.com</a> or call (833) 242-3330 for a list of <u>network providers</u> . * <u>Out-of-Network providers</u> may be treated as <u>In-Network providers</u> as required by No Surprises Act.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> /visit	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the deductible plus amounts billed by provider not paid by <u>plan</u>	<u>In-network</u> not subject to <u>deductible</u> . Teladoc Program - no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . Teladoc is an <u>in-network</u> benefit only – no coverage for a telemedicine program other than Teladoc.
	<u>Specialist</u> visit	\$40 <u>copayment</u> /visit		<u>In-network</u> not subject to <u>deductible</u> .
	<u>Preventive care/screening/</u> Immunization	No charge	Not covered	Coverage available <u>in-network</u> only. Immunizations available from any allowed <u>providers</u> , including pharmacies.  You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Network Provider (You will pay the least)  25% <u>coinsurance</u> after the deductible	Out-of-Network Provider (You will pay the most)  45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the deductible plus amounts billed by provider not paid by <u>plan</u>	none
	Imaging (CT/PET scans, MRIs)			
<p><b>-If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available by calling Express Scripts at (866) 685-2792.</p>		<u>Generic drugs</u>	Not covered	
		<u>Formulary brand drugs</u>		
		<u>Non-formulary brand drugs</u>		
		<u>Specialty drugs</u>		
<p><b>If you have outpatient surgery</b></p>		Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u> after the deductible	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u> unless otherwise required by No Surprises Act
		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 immediate medical attention	<a href="#">Emergency room care</a>	\$250 <u>copayment</u> /visit, then 25% <u>coinsurance</u> after the <u>deductible</u>	\$250 <u>copayment</u> /visit, then 25% of the Recognized Amount unless otherwise required by No Surprises Act	<u>Copayment</u> waived if patient is admitted to the <u>hospital</u> or if visit is due to an injury or life-threatening event.
	<a href="#">Emergency medical transportation</a>	25% <u>coinsurance</u> after the <u>deductible</u>	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> unless otherwise required by No Surprises Act	-----none-----
	<a href="#">Urgent care</a>	25% <u>coinsurance</u> after the <u>deductible</u>	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> unless otherwise required by No Surprises Act	<u>In-network</u> not subject to <u>deductible</u> . Teladoc Program - no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . Teladoc is an <u>in-network</u> benefit only – no coverage for a telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u> after the <u>deductible</u>	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u> unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate.  <u>Precertification</u> required.
	Physician/surgeon fees			-----none-----

Common Medical Event	Services You May Need	What You Will Pay			
	Outpatient services	Network Provider (You will pay the least) Out-of-Network Provider (You will pay the most)		Limitations, Exceptions, & Other Important Information	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In office physician visit: subject to \$20 <u>copayment</u> /visit only  25% <u>coinsurance</u> after the <u>deductible</u> for all other outpatient services.	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u> unless otherwise required by No Surprises Act		
	Inpatient services	25% <u>coinsurance</u> after the <u>deductible</u>		Residential Treatment Facility must be an <u>in-network facility</u> and is limited to 60 days per calendar year.  <u>Precertification</u> required.	
If you are pregnant	Office visits	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u>		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.	
	Childbirth/delivery professional services			<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> or a <u>deductible</u> may apply.	
	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	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a> after the <a href="#">deductible</a>	45% <a href="#">coinsurance</a> based on <a href="#">reasonable and customary charges</a> , after the <a href="#">deductible</a> plus amounts billed by provider not paid by <a href="#">plan</a>	Coverage is limited to 40 days max per year combined <a href="#">In</a> and <a href="#">out-of-network providers</a> .
	<a href="#">Rehabilitation services</a>		Not covered	Limit 70 combined visits per year combined <a href="#">In</a> and <a href="#">out-of-network providers</a> for combined Occupational, Physical and Speech Restorative Visits.
	<a href="#">Habilitation services</a>			Limit 60 days per calendar year. <a href="#">In-network</a> benefit only.
	<a href="#">Skilled nursing care</a>			Includes rental fees not to exceed the purchase price. Must meet <a href="#">medically necessary</a> requirements.
	<a href="#">Durable medical equipment</a>			Services can be provided through a freestanding <a href="#">hospice</a> facility or a <a href="#">hospice</a> program sponsored by a <a href="#">hospital</a> or <a href="#">home health care agency</a> or at a private residence.
	<a href="#">Hospice services</a>			
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 <a href="#">medically necessary</a> 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 <a href="#">deductible</a> .

### 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](http://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](http://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](http://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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist copayment</a>	\$40
■ <a href="#">Hospital (facility) coinsurance</a>	25%
■ <a href="#">Other coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<a href="#">Cost Sharing</a>	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$2,700

*What isn't covered*

Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$4,520</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist copayment</a>	\$40
■ <a href="#">Hospital (facility) coinsurance</a>	25%
■ <a href="#">Other coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<a href="#">Cost Sharing</a>	
Deductibles	\$900
Copayments	\$200
Coinsurance	\$0

*What isn't covered*

Limits or exclusions	\$3,500
<b>The total Joe would pay is</b>	<b>\$4,600</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist copayment</a>	\$40
■ <a href="#">Hospital (facility) coinsurance</a>	25%
■ <a href="#">Other coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<a href="#">Cost Sharing</a>	
Deductibles	\$1,750
Copayments	\$100
Coinsurance	\$200

*What isn't covered*

Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$2,060</b>



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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:
<u>What is the overall deductible?</u>	<p><u>In-Network</u>*: \$500/individual or \$1,000/family</p> <p><u>Out-of-Network</u>: \$1,000/individual or \$2,000/family</p> <p>*Certain <a href="#">out-of-network claims</a> are treated as <a href="#">in-network claims</a> as required by No Surprises Act.</p>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> unless the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<u>Are there services covered before you meet your deductible?</u>	<p><u>In-Network</u> Wellness &amp; <a href="#">Preventive Services</a>, Teladoc Doctor Visit, <a href="#">Prescription Drugs</a>, PPO or Premier Dental Services and Vision Benefits are covered before you meet your <a href="#">deductible</a>.</p>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">in-network preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<u>Are there other deductibles for specific services?</u>	Yes. For <a href="#">Non-Participating</a> Dentists, the <a href="#">deductible</a> is: \$50/individual or \$100/family	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<u>What is the out-of-pocket limit for this plan?</u>	<p><b>Medical:</b> <u>In-Network</u>*: \$3,500/individual or \$7,000/family. Unlimited for <u>Out-of-Network</u></p> <p>*Certain <a href="#">out-of-network claims</a> are treated as <a href="#">in-network claims</a> as required by No Surprises Act.</p> <p><b>Prescription:</b> \$5,600/individual or \$11,200/family. Unlimited for <a href="#">Out-of-Network</a>.</p>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<p><a href="#">Premiums</a>, <a href="#">balance billing</a> charges, <a href="#">non-network cost sharing</a>, health care this <a href="#">plan</a> doesn't cover, charges in excess of <a href="#">reasonable and customary</a> and penalties for failing to obtain <a href="#">preauthorization</a> for services.</p>	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes*. See <a href="http://www.ibxtpa.com">www.ibxtpa.com</a> or call (833) 242-3330 for a list of <u>network providers</u> . * <u>Out-of-Network providers</u> may be treated as <u>In-Network providers</u> as required by No Surprises Act.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> /visit	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the deductible plus amounts billed by provider not paid by <u>plan</u>	<u>In-network</u> not subject to <u>deductible</u> . Teladoc Program - no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . Teladoc is an <u>in-network</u> benefit only – no coverage for a telemedicine program other than Teladoc.
	<u>Specialist</u> visit	\$40 <u>copayment</u> /visit		<u>In-network</u> not subject to <u>deductible</u> .
	<u>Preventive care/screening/</u> Immunization	No charge	Not covered	Coverage available <u>in-network</u> only. Immunizations available from any allowed <u>providers</u> , including pharmacies.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)		45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the deductible plus amounts billed by provider not paid by <u>plan</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u> after the deductible		-----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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <a href="#">prescription drug coverage</a> is available by calling Express Scripts at (866) 685-2792.</p>	Generic <a href="#">drugs</a>	Retail – \$20 <a href="#">copayment/prescription</a> Smart 90 - \$50 <a href="#">copayment/prescription</a> Mail Order – \$50 <a href="#">copayment/prescription</a>	Retail – \$20 <a href="#">copayment/prescription</a> , plus any amount above <a href="#">reasonable and customary charges</a> Mail Order – Not covered	No <a href="#">deductible</a> on <a href="#">Prescription Benefits</a> . <a href="#">Copayments</a> do not apply to <a href="#">deductible</a> . Retail (30-day supply) – Participant pays the applicable <a href="#">copayment</a> at a network provider retail pharmacy using their Express Scripts card.
	Formulary brand <a href="#">drugs</a>	Retail – \$40 <a href="#">copayment/prescription</a> Smart 90 - \$100 <a href="#">copayment/prescription</a> Mail Order – \$100 <a href="#">copayment/prescription</a>	Retail – \$40 <a href="#">copayment/prescription</a> , plus any amount above <a href="#">reasonable and customary charges</a> Mail Order – Not covered	If the Participant uses an <a href="#">out-of-network provider</a> or does not use their Express Scripts card, the Participant pays 100% up front at retail pharmacy and then mails the <a href="#">claim</a> form to the Fund Office for reimbursement (less the <a href="#">copayment</a> plus amount above <a href="#">reasonable and customary charges</a> ).
	Non-formulary brand <a href="#">drugs</a>	Retail – \$80 <a href="#">copayment/prescription</a> Smart 90 - \$200 <a href="#">copayment/prescription</a> Mail Order – \$200 <a href="#">copayment/prescription</a>	Retail – \$80 <a href="#">copayment/prescription</a> , plus any amount above <a href="#">reasonable and customary charges</a> Mail Order – Not covered	Mail Order (90-day supply) – Participant pays only <a href="#">copayment</a> . Mail Order prescriptions can be obtained only through the Express Scripts Mail Order Service or the Smart 90 Retail or Mail Order Program.
	<a href="#">Specialty drugs</a>	Retail – 25% not to exceed a maximum of \$200 <a href="#">copayment/prescription</a> Mail Order – Not covered	Retail – 25% to a maximum of \$200 <a href="#">copayment/prescription</a> , plus any amount above <a href="#">reasonable and customary charges</a> Mail Order – Not covered	<a href="#">Precertification</a> is required for <a href="#">specialty drugs</a> and some injections. Clinical programs for some classes of <a href="#">drugs</a> 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.

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)		45% <a href="#">coinsurance</a> based on <a href="#">reasonable and customary charges</a> , after the <a href="#">deductible</a> plus amounts billed by provider not paid by <a href="#">plan</a> unless otherwise required by No Surprises Act	-----none-----
	Physician/surgeon fees	25% <a href="#">coinsurance</a> after the <a href="#">deductible</a>		
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copayment</a> /visit, then 25% <a href="#">coinsurance</a> after the <a href="#">deductible</a>	\$250 <a href="#">copayment</a> /visit, then 25% of the Recognized Amount unless otherwise required by No Surprises Act	<a href="#">Copayment</a> waived if patient is admitted to the <a href="#">hospital</a> or if visit is due to an accidental or life-threatening event.
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a> after the <a href="#">deductible</a>	45% <a href="#">coinsurance</a> based on <a href="#">reasonable and customary charges</a> , after the <a href="#">deductible</a> unless otherwise required by No Surprises Act	-----none-----
	<a href="#">Urgent care</a>	25% <a href="#">coinsurance</a> after the <a href="#">deductible</a>	45% <a href="#">coinsurance</a> based on <a href="#">reasonable and customary charges</a> , after the <a href="#">deductible</a> unless otherwise required by No Surprises Act	<a href="#">In-network</a> not subject to <a href="#">deductible</a> . Teladoc Program - no <a href="#">copayment</a> , <a href="#">deductible</a> or <a href="#">coinsurance</a> . Teladoc is an <a href="#">in-network</a> benefit only – no coverage for a telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)		45% <a href="#">coinsurance</a> based on <a href="#">reasonable and customary charges</a> , after the <a href="#">deductible</a> plus amounts billed by provider not paid by <a href="#">plan</a> unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate.  <a href="#">Precertification</a> required.
	Physician/surgeon fees	25% <a href="#">coinsurance</a> after the <a href="#">deductible</a>		-----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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	In office physician visit: subject to \$20 <u>copayment</u> /visit only  25% <u>coinsurance</u> after the <u>deductible</u> for all other outpatient services	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u> unless otherwise required by No Surprises Act	<u>In-network</u> in office <u>physician</u> visit not subject to <u>deductible</u> . Teladoc Program – no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . Teladoc is an <u>in-network</u> benefit only – no coverage for a telemedicine program other than Teladoc.
	Inpatient services	25% <u>coinsurance</u> after the <u>deductible</u>		Residential Treatment Facility must be an <u>in-network facility</u> and is limited to 60 days per calendar year.  <u>Precertification</u> required.
<b>If you are pregnant</b>	Office visits	25% <u>coinsurance</u> after the <u>deductible</u>	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u> 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.
	Childbirth/delivery professional services			<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> or a <u>deductible</u> may apply.
	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	<a href="#">Home health care</a>	25% <u>coinsurance</u> after the <u>deductible</u>	45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u>	Coverage is limited to 40 days max per year combined <u>In</u> and <u>out-of-network providers</u> .
	<a href="#">Rehabilitation services</a>		Not covered	Limit 70 combined visits per year combined <u>In</u> and <u>out-of-network providers</u> for combined Occupational, Physical and Speech Restorative Visits.
	<a href="#">Habilitation services</a>		45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u>	Limit 60 days per calendar year. <u>In-network</u> benefit only.
	<a href="#">Skilled nursing care</a>		45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u>	Includes rental fees not to exceed the purchase price. Must meet <u>medically necessary</u> requirements.
	<a href="#">Durable medical equipment</a>		45% <u>coinsurance</u> based on <u>reasonable and customary charges</u> , after the <u>deductible</u> plus amounts billed by provider not paid by <u>plan</u>	Services can be provided through a freestanding <u>hospice</u> facility or a <u>hospice</u> program sponsored by a <u>hospital</u> or <u>home health care agency</u> or at a private residence.
	<a href="#">Hospice services</a>			
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 <u>medically necessary</u> 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 <u>deductible</u> .

### 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](http://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](http://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](http://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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$40
■ <a href="#">Hospital (facility) coinsurance</a>	25%
■ <a href="#">Other coinsurance</a>	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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$3,000

#### *What isn't covered*

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,570</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$40
■ <a href="#">Hospital (facility) coinsurance</a>	25%
■ <a href="#">Other coinsurance</a>	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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$100

#### *What isn't covered*

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$40
■ <a href="#">Hospital (facility) coinsurance</a>	25%
■ <a href="#">Other coinsurance</a>	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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$400

#### *What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>



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