





Ohio Carpenters' Fringe Benefit Funds

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

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

December 2023

IMPORTANT NOTICE – 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.

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.

Summary of Benefits and Coverage

Enclosed please find your Summary of Benefits and Coverage ("SBC"), 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 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.

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

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.
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)		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		25% coinsurance after the deductible	
If you need immediate medical attention	Emergency room care		\$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		45% coinsurance based on reasonable and customary charges , after the deductible unless otherwise required by No Surprises Act	-----none-----
	Urgent care		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.
			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	
If you have a hospital stay	Facility fee (e.g., hospital room)		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		25% coinsurance 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)	
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		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.
	Childbirth/delivery professional services	25% coinsurance after the deductible		Cost sharing does not apply for preventive services . Depending on the type of services, coinsurance or a deductible 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	Home health care		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			Limit 60 days per calendar year. In-network benefit only.
	Skilled nursing care	25% coinsurance after the deductible	Not covered	Includes rental fees not to exceed the purchase price. Must meet medically necessary requirements.
	Durable medical equipment		45% coinsurance based on reasonable and customary charges , after the deductible plus amounts billed by provider not paid by plan	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	Hospice services			
	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	• Cosmetic surgery	• Long-term care
• Bariatric surgery	• Infertility treatment	• 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)	• Non-emergency care when traveling outside the U.S. (see www.bcbglobalcare.com)	• Routine eye care (adult)
• Dental care (adult)	• Private-duty nursing	• Weight loss program (ESI weight management program only)
• Hearing aids		

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](#) \$500
- [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.



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**OHIO CARPENTERS'
FRINGE BENEFIT FUNDS**

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