Central Midwest Regional Council of Carpenters'
Welfare Fund

P.O. Box 1257, Troy, MI 48099
(800) 700-6756

December 2025

IMPORTANT NOTICE – SUMMARY OF BENEFITS AND COVERAGE

MEDICARE ADVANTAGE RETIREES

Dear Plan Participant:

This notice contains important information regarding coverage as a participant in the Central Midwest Regional Council of Carpenters' Welfare Fund. If you have any questions regarding the content of this notice, or your coverage in general, please contact the Fund Office at (800) 700-6756.

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 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?	$0	See the Common Medical Events chart below for your costs for services this plan covers. This is a Medicare Advantage plan.
Are there services covered before you meet your deductible?	Not Applicable	This plan does not have a deductible. This is a Medicare Advantage plan.
Are there other deductibles for specific services?	Yes. Out-of-Network Dental Benefits - $50/person and $100/family each calendar year. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. This is a Medicare Advantage plan.
What is the out-of-pocket limit for this plan?	Rx: $2,100/individual for formulary drugs covered by Medicare	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?	Out-of-network charges in excess of plan allowances, premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
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 Provide	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge		----------none----------
	Specialist visit	No charge		----------none----------
	Preventive care/screening/ immunization	No charge		----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge		----------none----------
	Imaging (CT/PET scans, MRIs)	No charge		----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provide	Out-of-Network Provider	
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** contact the Fund Office at (855) 837-3528.	Generic drugs	Retail 31-day supply: $10 copayment/prescription Retail 60-day supply: $20 copayment/prescription Retail 90-day supply: $30 copayment/prescription Mail Order 90-day supply: $20 copayment/prescription		Retail is up to 90-day supply. Mail Order is 90-day supply. If generic equivalent is available; you will be required to pay the price difference between the generic drug and the preferred brand name drug unless prescription notes "dispense as written."
	Preferred brand drugs	Retail 31-day supply: $30 copayment/prescription Retail 60-day supply: $60 copayment/prescription Retail 90-day supply: $90 copayment/prescription Mail Order 90-day supply: $60 copayment/prescription		
	Non-preferred brand drugs	Retail 31-day supply: $75 copayment/prescription Retail 60-day supply: $150 copayment/prescription Retail 90-day supply: $225 copayment/prescription Mail Order 90-day supply: $150 copayment/prescription		
	Specialty drugs	Retail 31-day supply: $100 copayment/prescription Retail 60-day supply: $200 copayment/prescription Retail 90-day supply: $300 copayment/prescription Mail Order 90-day supply: $200 copayment/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		----------none----------
	Physician/surgeon fees	No charge		----------none----------
If you need immediate medical attention	Emergency room care	No charge		----------none----------
	Emergency medical transportation	No charge		----------none----------
	Urgent care	No charge		----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provide	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to the Medicare Allowed Amount per Medicare benefit period, 100% of charges once Medicare is exhausted.		----------none----------
	Physician/surgeon fees			----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge		----------none----------
	Inpatient services	No charge		----------none----------
If you are pregnant	Office visits	No charge		----------none----------
	Childbirth/delivery professional services	No charge		----------none----------
	Childbirth/delivery facility services	No charge		----------none----------
If you need help recovering or have other special health needs	Home health care	No charge		----------none----------
	Rehabilitation services	No charge		----------none----------
	Habilitation services	No charge		----------none----------
	Skilled nursing care	No charge for the first 100 days. 100% of charges for day 101 and beyond.		----------none----------
	Durable medical equipment	No charge		----------none----------
	Hospice services	No charge		----------none----------
If your child needs dental or eye care	Children's eye exam	No coverage.		No coverage under Medicare Advantage Plan, but coverage under Active Plan. See Active SBC.
	Children's glasses	No coverage.		No coverage under Medicare Advantage Plan, but coverage under Active Plan. See Active SBC.
	Children's dental check-up	No coverage.		No coverage under Medicare Advantage Plan, but coverage under Active Plan. See Active SBC.

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.)		
• Acupuncture	• Long-term care	• Routine foot care
• Cosmetic surgery (unless medically necessary)	• Non-emergency care when traveling outside the U.S. (see www.bcbsglobalcore.com)	• Weight loss programs (ESI weight loss program only)
• Infertility treatment		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (if Plan guidelines are met)	• Dental care (adult)	• Private-duty nursing (if Plan guidelines are met)
• Chiropractic care	• Hearing aids (up to $3,000 every 3 years)	• Routine eye care (adult)

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 (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.

Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf (855) 837-3528 uff.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0[1]
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments[2]	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

[1] Assumes member is using a Medicare provider.
[2] Copayments apply to prescriptions.

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

The plan's overall deductible	$0[1]
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$5,300

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments[2]	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

[1] Assumes member is using a Medicare provider.
[2] Copayments apply to prescriptions.

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

The plan's overall deductible	$0[1]
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$10**

[1] Assumes member is using a Medicare provider

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

CENTRAL MIDWEST REGIONAL COUNCIL
OF CARPENTERS' WELFARE FUND
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Important Fund Information