



Central Midwest Regional Council of Carpenters' Welfare Fund

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

December 2024

IMPORTANT NOTICE – SUMMARY OF BENEFITS AND COVERAGE

MEDICARE SUPPLEMENT RETIREES

Dear Plan Participant:

This notice contains important information regarding coverage as a participant in the Central Midwest Regional Council of Carpenters' Welfare Fund. 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 (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 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, contact the Plan at: (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 www.dol.gov/ebsa/healthreform or call (855) 837-3528 to request a copy.

THIS PLAN ONLY PAYS BENEFITS SUPPLEMENTAL TO MEDICARE. IT DOES NOT COVER SERVICES NOT COVERED ON A PRIMARY BASIS BY MEDICARE. IF MEDICARE IS NOT TIMELY OBTAINED, THIS PLAN WILL NOT COVER EXPENSES THAT WOULD HAVE BEEN PAID BY MEDICARE. SEE PAGE 8.

| 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 supplemental plan. See page 8. |
| Are there services covered before you meet your deductible ? | Not Applicable | This plan does not have a deductible . This is a Medicare supplemental plan. See page 8. |
| Are there other deductibles for specific services? | There are no other specific deductibles . | You don't have to meet deductibles for specific services. This is a Medicare supplemental plan. See page 8. |
| What is the out-of-pocket limit for this plan ? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. This is a Medicare supplemental plan. See page 8. |
| What is not included in the out-of-pocket limit ? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. This is a Medicare supplemental plan. See page 8. |
| Will you pay less if you use a network provider ? | Yes. Medicare-approved providers are network providers | If you do not use a Medicare approved provider, benefits will only be paid up to the amount that would have been paid had a Medicare approved provider been used. However, you must have Medicare coverage to obtain any benefits whether or not you use a Medicare approved provider. |
| Do you need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . This is a Medicare supplemental plan. See page 8. |

 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 |
|--|--|--|---|---|
| | | Your Cost If You Use a Medicare Provider | Your Cost If You Do Not Use a Medicare Provider | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Specialist visit | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Preventive care/screening/immunization | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Imaging (CT/PET scans, MRIs) | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|---|
| | | Your Cost If You Use a Medicare Provider | Your Cost If You Do Not Use a Medicare Provider | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling (866) 685-2792. | Generic | Not Covered | | This Plan does not cover prescription drugs . |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs | | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Physician/surgeon fees | | | |
| If you need immediate medical attention | Emergency room care | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Emergency medical transportation | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Urgent care | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| 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 | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Physician/surgeon fees | | | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Your Cost If You Use a Medicare Provider | Your Cost If You Do Not Use a Medicare Provider | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Inpatient services | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| If you are pregnant | Office visits | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Childbirth/delivery professional services | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Childbirth/delivery facility services | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| If you need help recovering or have other special health needs | Home health care | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Rehabilitation services (Physical Therapy) | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Habilitation services (Occupational and Speech Therapy) | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Skilled nursing care | No charge for the first 100 days. 100% of charges for day 101 or beyond | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|---|
| | | Your Cost If You Use a Medicare Provider | Your Cost If You Do Not Use a Medicare Provider | |
| If you need help recovering or have other special health needs (continued) | Durable medical equipment | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| | Hospice services | No charge | 100% of charges above the Medicare Allowed Amount | This Plan pays supplemental to Medicare only. |
| If your child needs dental or eye care | Children's eye exam | No coverage. | | No coverage under Medicare Supplement Plan, but coverage under Active Plan. See Active SBC. |
| | Children's glasses | No coverage. | | No coverage under Medicare Supplement Plan, but coverage under Active Plan. See Active SBC. |
| | Children's dental check-up | No coverage. | | No coverage under Medicare Supplement 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](#) and [limitations of coverage](#).)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aid
- Infertility Treatment
- Long-term Care
- [Prescription drugs](#)
- [Routine eye care \(adult\)](#)
- Routine Foot Care
- Weight Loss Programs

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 travelling outside the U.S. for no more than 30 days
- Private-duty nursing

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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 Plan at 855-837-3528 or EBSA at 1-866-444-3272 or www.dol.gov/ebsa. Additionally, a consumer assistance program can help you file your appeal. Contact: Ohio Department of Insurance at (800) 686-1526 or www.insurance.ohio.gov/Pages/default.aspx.

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 copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other | 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 | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|-------------|
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$70 |

¹ Assumes member is using a Medicare provider.

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 copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other | 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 **\$5,600**

In this example, Joe would pay:

| Cost Sharing | |
|------------------------------|-----|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$3,500 |
| The total Joe would pay is | \$3,500 |

¹ Assumes member is using a Medicare provider.

Mia's Simple Fracture

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

| | |
|---|------------------|
| ■ The plan's overall deductible | \$0 ¹ |
| ■ Specialist copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other | 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 | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|-------------|
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$10 |

¹ Assumes member is using a Medicare provider.

AS NOTED ABOVE, THIS PLAN ONLY PAYS BENEFITS SUPPLEMENTAL TO MEDICARE. IT DOES NOT COVER SERVICES NOT COVERED ON A PRIMARY BASIS BY MEDICARE. IF MEDICARE IS NOT TIMELY OBTAINED, THIS PLAN WILL NOT COVER EXPENSES THAT WOULD HAVE BEEN PAID BY MEDICARE. The Schedule of Medicare Supplemental Benefits provided by this Plan are:

Part A Supplemental Benefits – Inpatient Benefits for Medicare covered services received in a Medicare approved facility:

- Part A deductible for the first 60 days of Hospital care per Medicare Benefit Period.
- The Part A coinsurance for the 61st through the 90th day of Hospital care per Medicare Benefit Period.
- The Part A coinsurance for lifetime reserve days.
- The first three pints of blood that you receive each calendar year.
- Part A coinsurance for hospice care services and home health care services.
- Part A coinsurance for the 21st through the 100th day of care in a Skilled Nursing Facility.

Part B Supplemental Benefits – Outpatient Benefits

- Part B deductible.
- Part B blood copayment or provider costs for the first three pints of blood each calendar year.
- Part B coinsurance.