Central Midwest Regional Council of Carpenters' Welfare Fund

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

Welcome to the Central Midwest Regional Council of Carpenters' Benefits Plan!

Dear Central Midwest Regional Council of Carpenters' Participant:

This enrollment package was sent to you because you are, or will be, eligible for health care coverage. In order to better understand the benefits that are available to you, it is important that you carefully read all of the information included. It is equally important that you fully and legibly complete and return all required documents as soon as possible. Any missing information or incomplete forms will delay the processing of your medical and/or dental claims.

Enclosed please find:

Vital Information Form:
Please fill out **both sides** of this form and return it to the Benefit office. List your spouse and any dependent children that you wish to have covered under the Central Midwest Regional Council of Carpenters' Welfare Fund plan. In the 'Beneficiary Information' portion, list any beneficiaries you wish to receive benefits that may be payable upon your death. The back of this form must also be completed. This provides the Benefit office with information regarding other insurance policies you or your dependents may have.

Dependent Coverage Letter:
This letter explains what documents you will need to add your spouse, dependent child(ren), stepchild(ren), and/or adopted child(ren). Please be advised if you do not return the necessary documentation your dependent(s) will **not** be added to your coverage. **You must provide a copy of your marriage certificate to add your spouse and birth certificates to add dependent children.**

Authorization for Release of Protected Health Information:

Please read the enclosed HIPPA Privacy notice, which explains your rights, and how and when medical information may be disclosed. In order for you or your spouse, if applicable, to receive health care information over the phone for any member of your family over 18, a signed authorization form must be on file at this office. **Please complete and sign the enclosed Authorization for Release of Protected Health Information form and return it to the Benefit Office.**

Notices of COBRA Continuation Coverage Rights:

Please read this information. This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of health coverage under the Plan.

Independence PPO Benefits-at-a Glance:

This is a summary of the medical benefits that are available with Independence PPO insurance. ***To find a physician who participates with your Independence PPO plan you can contact Customer Service at 1-833-242-3330 or visit their website at www.MyIBXTPAbenefits.com.***

Express Scripts Drug Plan:

Once you become eligible for coverage you will be mailed an Express Scripts Prescription Welcome Kit. This kit explains your prescription drug benefits, pharmacy options and mail order instructions. ***To find an Express Scripts pharmacy in your area or check your Mail Order status you can visit the website at www.Express-Scripts.com or call Customer Service at 1-800-867-4518.***

Delta Dental Information:

This is a summary of the dental benefits that are available with Delta Dental. ***For inquiries about your Delta Dental Plan of or to find a participating dentist please call 1-800-524-0149.***

Vision Service Plan Information:

This is a summary of the vision benefits that are available with VSP. ***For inquiries about your Vision Service Plan please call 1-800-877-7195 or log on to www.vsp.com.***

Virtual Second Options By the Cleveland Clinic:

This flyer provides contact information for your Virtual Second Options benefit through the Cleveland Clinic. ***For inquiries about your Virtual Second Options By the Cleveland Clinic log on to www.clinicbyclevelandclinic.com/central-midwest-carpenters.***

Teladoc Telemedicine:

This flyer provides sign up and contact information for your Telemedicine benefit through Teladoc. ***For inquiries about Teladoc please call 1-800-835-2362 or log on to www.TeladocHealth.com.***

TruHearing

This flyer provides contact information for your Hearing Aid Benefit through Tru Hearing. ***For inquiries about Tru Hearing please call 1-877-653-8876.***

*****IMPORTANT NOTICE*****

If you have any questions or wish to receive a Certificate of Creditable Coverage please contact the Insurance Fund Office by phone at 800-700-6756 or by mail at Central Midwest Regional Council of Carpenters' Welfare Fund P O Box 1257, Troy, MI 48099.

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at *www.dol.gov/ebsa*. State and local government employees should contact HHS-CMS at *www.cms.hhs.gov/COBRAContinuationofCov/* or *NewCobraRights@cms.hhs.gov*.

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ENROLLMENTDOCS@BENESYS.COM

VITAL INFORMATION FORM

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____ Gender :(*circle one*) Male Female

Marital Status: *(circle one*) Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Current Status: *(circle one)* Active Retired Disabled COBRA

Telephone Number: (_____) _____ Alternate Phone Number: (_____) _____

Email Address: _____

Employer_____ Initiation Date: _____

Home Local: _____ Home Fund: _____ UBC#_____

Medicare Claim Number: (including the letter(s) that follows the number)
(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ **Spouse #** _____ **Dependent # and Name** _____

DEPENDENTS: - Include Spouse (*Marriage/Birth Certificates are needed to add any new dependents to the plan)*

FULL NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH

BENEFICIARY INFORMATION: (For the Life Insurance Benefit for the CMRCC Welfare Fund, only)

NAME	RELATION	SS #	BIRTHDAY	ADDRESS/CITY/STATE/ZIP	%
(Primary)		___-___-___	___/___/____		
		___-___-___	____/___/____		
(Secondary)		___-___-___	____/___/____		
		___-___-___	____/___/____		

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

_____ _____
MEMBER SIGNATURE **Date** **(OVER)**

OTHER INSURANCE INQUIRY

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage that you participate in, or if there has been any change in other insurance coverage.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____) _____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

_____

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

I Have No Other Insurance: _____
Initial Here/Sign Below

Member Signature:_____ **Date:** _____

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DEPENDENT COVERAGE

Please read the following information carefully! This letter explains the necessary requirements and documentation needed to add dependents to your health care coverage. Please refer only to the situation which applies to you and forward the required information to the Benefit Office.

SPOUSE - Coverage for a spouse can be provided for any eligible active participant. You are required to complete a *Vital Information Form* for the purpose of verifying any other active insurance coverage. When adding a new spouse to your policy a copy of your marriage certificate is required before coverage will be activated. **Please do not send original document(s)**.

CHILDREN - The active participants' natural dependent children and legally adopted children are eligible to be added to your policy. When adding eligible dependents to your policy a copy of each child's birth certificate is required before coverage will be activated. **Please do not send original document(s)**.

STEPCHILDREN - Please be advised stepchildren are not automatically eligible dependents. If you are 100% responsible for the stepchildren, and their non-custodial parent has relinquished all legal claims and rights to said children, please forward the child's birth certificate and the legal documents to the Benefit Office for review. If action has not been pursued by the dependent's custodial parent, the Fund cannot be responsible for their Primary Health Care coverage. However you may submit for review, any legal documents such as a prior divorce decree, or a Paternity affidavit, a copy of your taxes showing you claim the child as a dependent. **Please do not send original document(s)**.

DEPENDENTS AGE 19 – 26 - In accordance with the Patient Protection and Affordable Care Act (PPACA also known as Healthcare Reform) health care plans that offer coverage for dependent children must provide coverage for adult children of covered employees until the age of 26. It is no longer a requirement that a dependent child over the age of 19 be a full-time student. Therefore your children may be eligible for coverage until they attain age 26, regardless of; their student or marital status; whether your home is their principal place of residence or whether you support them. A copy of the child's birth certificate must be submitted before coverage will be activated. **Please do not send original document(s)**.

By providing our office with any information in regards to other insurance coverage your spouse and/or children may have in addition to the Central Midwest Regional Council of Carpenters' Welfare Fund, you are doing your part in controlling the escalating costs of the Health Plan Benefits.

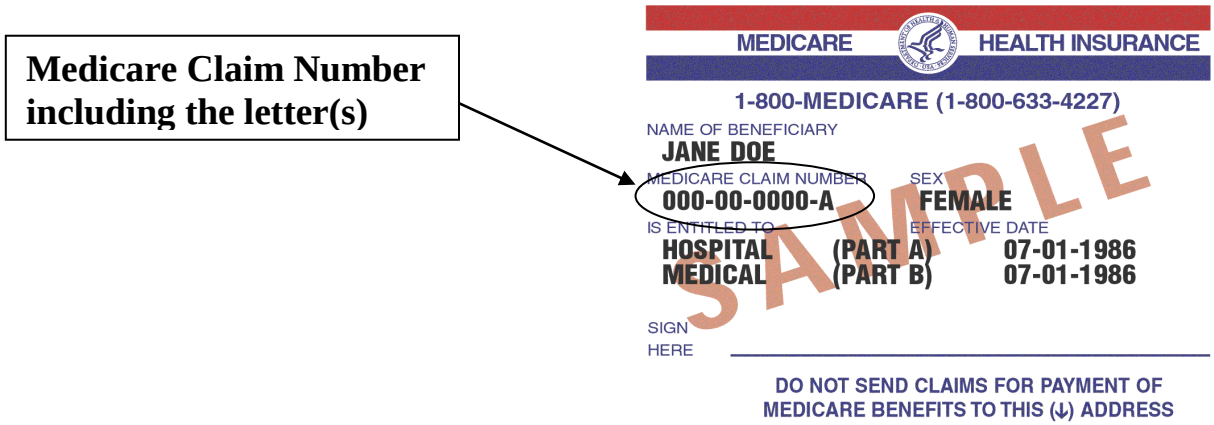
IMPORTANT!
Instructions for Vital Information Form and Authorization for Release of Protected Health Information

It is necessary for you to complete and return the attached forms entitled *Vital Information Form* and *Authorization for Release of Protected Health Information*. Completion of these forms will allow the Benefit Office to process your health benefits properly and in a timely manner. The Benefit Office requests that you complete and return these forms immediately upon receipt.

Instructions for *Vital Information Form*

All the information on the front of the form must be completed and the form must be signed. The back of the form regarding *Other Insurance* need only be completed if you, your spouse, or any of your dependents have other insurance coverage.

If you, your spouse, or your covered dependents are age 65 or older or eligible for Medicare disability benefits, it is extremely important that you complete the line on the form regarding Medicare Claim Numbers. The illustration below shows where the number is located on the Medicare card.



Instructions for *Authorization for Release of Protected Health Information*

Privacy regulations require the Benefit Office to have authorization to discuss health care and eligibility information over the phone. The *Authorization for Release of Protected Health Information* allows you to permit the Benefit Office to discuss health care and eligibility information with the person(s) you designate on the form. If you so choose, the form also permits you to limit the release of health information to yourself only.

If the Authorization Form is not completed and returned, discussions regarding health care will be limited to yourself and any minor children enrolled under your coverage. This means that if your spouse calls the Benefit Office with a question about a benefit paid on your behalf, we will not be able to release the information. Similarly, if your spouse does not give authorization for us to talk to you, you will not be able to inquire about a claim paid on your spouse.

Please review the instructions for completing the *Authorization for Release of Protected Health Information* that are located on the back of the form.

If you have any question regarding these forms, please contact the Benefit Office at (800) 700-6756.

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NOTICE OF THE PRIVACY PRACTICES OF THE CENTRAL MIDWEST REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully And Contact the Plan Office If You Have Any Questions.

We are required by law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that medical information that identifies you is kept private to the extent required by law. We are also required to give you this notice regarding (1) the uses and disclosures of medical information that may be made by the Plan, and (2) your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment.
Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, we may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

For Payment.
We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the coordination of benefit payments.

For Health Care Operations.
We may use and disclose medical information about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities.

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As Required By Law.
We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action. When authorized by law to report information about abuse, neglect or domestic violence to public authorities, we may disclose medical information if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such a case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's health information.

To Avert a Serious Threat to Health or Safety.
We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

To Inform You About Treatment Alternatives or Other Health Related Benefits.
We may use PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. For instance, we may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.

Disclosure to Health Plan Sponsor.
Medical information may be disclosed to the Plan Sponsors, i.e. the Union and the Associations, or Plan Trustees, solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation.
If you are an organ donor, we may release medical information to organizations that handle organ procurement or transplantation.

Military and Veterans.
If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation.
We may release medical information about you for workers' compensation or similar programs.

Public Health Risks.
We may disclose medical information about you for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury or disability.

Health Oversight Activities.
We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure.

Lawsuits and Disputes.
We may disclose medical information in response to a court order or administrative tribunal. We may also disclose medical information in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if we receive satisfactory assurance from the party seeking the information that reasonable efforts have been made to notify you of the request or, if such assurance is not forthcoming, if we have made a reasonable effort to notify you about the request.

Law Enforcement.
We may release medical information if asked to do so for law enforcement purposes so long as applicable legal requirements have been met.

Coroners, Medical Examiners and Funeral Directors.
We may release medical information to a coroner or medical examiner.

Research.
We may disclose medical information for research, subject to conditions.

National Security and Intelligence Activities.
We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates.
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy.
You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend.
If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your health information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity - that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) or is accurate and complete.

Right to an Accounting of Disclosures.
You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures, other than disclosures made (1) to carry out treatment, payment or health care operations, (2) to individuals about their own medical information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for other national security or to correctional institutions or law enforcement officials, or (8) before April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions.
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications.
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan shall accommodate such a request if the participant clearly provides information that the disclosure of all or part of that information could endanger the participant. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice.
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to This Notice

The effective date of this Notice is April 14, 2003. We reserve the right to (1) change this notice, and (2) to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If any changes are made, we will mail the revised Notice to participants. The Plan will comply with the terms of any such Notice currently in effect.

Complaints/Requests for Information

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, or to receive further information as required by the regulations, contact Sherry Verstraete at the Plan Office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Participant/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Participant Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-
   If you are not married or **you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself". **Please sign and date below the box**.

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (participant/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).
   If you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box**.

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
   If want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. Please sign and date form below the box.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

MEMBER / RETIREE SECTION

I, (print name and social security number) _____ SSN#___ ___ ___/___ ___/___ ___ ___ __
authorize the Health Fund (the "Fund"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Fund, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

HIPAA - Eligibility
Central Midwest Regional Council of Carpenters' Welfare Fund
P.O. Box 1257
Troy, MI 48099
or Email:ENROLLMENTDOCS@BENESYS.COM

Phone: (800)700-6756
www.in-kycarpentersbenefits.org

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Fund cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member_____**Date Signed:** _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member_____**Date Signed**: _____

SPOUSE SECTION

I, the **Spouse** (**Name, Please Print**) _____, (**Spouse's Social Security #**) _____of the above named member, have also read, understand, and authorize the Fund to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse_____**Date Signed**: _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse _____ **Date Signed**: _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the **Dependent Child(ren)** over the age of 18 (**Name, Please Print)**_____,**(Social Security #)** _____have also read, understand, and authorize the Fund to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent_____**Date Signed**: _____

OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Dependent _____**Date Signed**: _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Fund Office.

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Notice of COBRA Continuation Coverage Rights
Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

Your hours of employment are reduced, or
Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plan and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, retirement or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Central Midwest Regional Council of Carpenters' Welfare Fund, P. O. Box 1257, Troy, MI 48099

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:

Central Midwest Regional Council of Carpenters' Welfare Fund
P. O. Box 1257, Troy, MI 48099
(800) 700-6756

Central Midwest Regional Council of Carpenters' Welfare Fund

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

NOTICE OF NONDISCRIMINATION

Central Midwest Regional Council of Carpenters' Welfare Fund ("the Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call the Health Plan at (800) 700-6756 and ask for assistance.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: FOR FREE LANGUAGE ASSISTANCE CALL 1 (800) 700-6756

Language	Message About Language Assistance
Español Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 700-6756.
繁體中文 Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 700-6756.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (800) 700-6756.
Tiếng Việt Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 700-6756.
한국어 Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 700-6756 전화해 주십시오.
لعربية Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 (800) 700-6756
ܣܘܪܝܝܐ Assyrian	ܐܫܘܪ: ܐܢ ܐܢܬ ܡܬܟܠܡ ܠܫܢ ܐܬܘܪܝܐ، ܐܝܟ ܡܫܬܡܫ ܒܫܝܪܘܬ ܕܥܙܪܐ ܠܫܢ ܕܡܬܟܠ ܒܚܠܦ ܠܟ ܒܠܐ ܡܚܝܪ. ܩܒܠ ܠ 1 (800) 700-6756
Shqip Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1 (800) 700-6756
日本語 Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 700-6756まで、お電話にてご連絡ください。
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1 (800) 700-6756
Tagalog Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 700-6756.
Русский Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 700-6756.
Polski Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 (800) 700-6756
Srpsko-hrvatski Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1 (800) 700-6756.
Italiano Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1 (800) 700-6756

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?	In-Network: $500/individual or $1,000/family Out-of-Network: $500/individual or $1,250 family *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible unless the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network Preventive Care, primary care visits, specialist visits, and Dental Preventive Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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.
What is the out-of-pocket limit for this plan?	In-Network Medical: $3,500/individual or $7,000/family Prescription: $5,700/individual or $11,400/family Out-of-Network Medical: $5,000/individual or $10,000/family Prescription: No limit *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	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.

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,	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network not subject to deductible. Teladoc – no copayment, deductible or coinsurance. Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc.
	Specialist visit	$40 copayment/visit		
	Preventive care/screening/ immunization	No charge	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network providers not subject to the deductible. Plan covers preventive services and supplies required by ACA. Age and frequency guidelines apply to covered preventive care. 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)	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	----------none----------
	Imaging (CT/PET scans, MRIs)			

*For more information about limitations and exceptions, see summary plan description (SPD).

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 For more information about **prescription drug coverage** contact the Fund Office at(855) 837-3528.	Generic drugs	Retail - $20 copayment/ prescription (for 1st 3 fills of same drug); 100% up to $100 copayment/ prescription (for 4th or more fills of same drug) Smart 90 / Mail Order - $50 copayment/prescription	Submit original receipts to Fund Office for reimbursement, which will not exceed the amount the Fund would have paid an in-network pharmacy.	Maintenance drugs must be filled through the Smart 90 Retail or Mail Order Program. Retail is up to 90-day supply. Mail Order is up to 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 Physician requests brand-name drug. Clinical programs for some classes of drugs include prior authorization, step therapy, and/or quantity limits. Certain weight loss drugs may be covered.*
	Preferred drugs	Retail - $40 copayment/ prescription (for 1st 3 fills of same drug); 100% up to $100 copayment/ prescription (for 4th or more fills of same drug) Smart 90 / Mail Order - $100 copayment/prescription		
	Non-Preferred brand drugs	Retail - $80 copayment/ prescription (for 1st 3 fills of same drug); 100% up to $100 copayment/ prescription (for 4th or more fills of same drug) Smart 90 / Mail Order - $200 copayment/prescription		
	Specialty drugs	25% coinsurance up to $200		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	----------none----------
	Physician/surgeon fees			

*For more information about limitations and exceptions, see summary plan description (SPD).

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	Emergency room care	$250 copayment/visit, then 20% coinsurance after deductible	$250 copayment/visit, then 20% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	$250 copayment waived if the patient is admitted to the hospital or if the reason for the visit to the emergency room is due to an accidental injury or life-threatening condition.
	Emergency medical transportation	20% coinsurance after deductible	Ground: 40% coinsurance based on Applicable Medicare Rate after deductible Air: 20% coinsurance (lesser of billed charges or the Qualified Payment Amount) unless otherwise required by No Surprises Act	To and from the hospital for a covered inpatient admission or initial treatment of an Emergency Medical Condition provided by a hospital or a government-certified ambulance service.
	Urgent care	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Teladoc – no copayment, deductible or coinsurance. Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate. Prior authorization required.
	Physician/surgeon fees			----------none----------

*For more information about limitations and exceptions, see summary plan description (SPD).

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: primary care: $20 copayment/visit; Specialist: $40 copayment/visit 20% coinsurance after deductible for all other outpatient services.	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Teladoc – no copayment, deductible or coinsurance. Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc. Care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a licensed social worker.
	Inpatient services	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Prior authorization required. Residential Treatment Facility covered in-network only and limited to 60 days per year.
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Maternity care may include tests and services described elsewhere in this document (i.e., ultrasound). Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance or a deductible may apply. Newborn care is not provided for the newborns of Dependent Children. Maternity care is provided for Dependent Children.
	Childbirth/delivery professional services	20% coinsurance after deductible		
	Childbirth/delivery facility services	20% coinsurance after deductible		Inpatient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery. Pregnancy of a dependent child is covered.

*For more information about limitations and exceptions, see summary plan description (SPD).

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	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Limit 40 visits per year.
	Rehabilitation services			----------none----------
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% coinsurance after deductible	Not covered	Prior authorization required. Limit 60 days per calendar year.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Includes rental fees not to exceed purchase price. Expenses for special fittings, adaptations, maintenance, or repairs are not covered.
	Hospice services			Must be provided at freestanding hospice facility or by a hospice program sponsored by a hospital or Home Health Care Agency. Hospice services may be received in a private residence.
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. This plan covers certain preventive services without cost-sharing and before you meet your deductible, including vision screening for all children. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
	Children's glasses	No charge for medically necessary services for children up to age 19		Limited to once every 24 months. This plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits
	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.

*For more information about limitations and exceptions, see summary plan description (SPD).

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
- Cosmetic surgery (unless Medically Necessary)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. (see www.bcbsglobalcore.com)
- Routine foot care
- Weight loss programs (ESI weight management program only)

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)
- Chiropractic care (25 visits per year)
- Dental care (adult)
- Hearing aids
- Private-duty nursing (if Plan guidelines are met; 90 visits per Plan year)
- 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.

Pennsylvania 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.

*For more information about limitations and exceptions, see summary plan description (SPD).

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	20%
Other coinsurance	20%

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	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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	20%
Other coinsurance	20%

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	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,200**

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	20%
Other coinsurance	20%

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	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

Log in to your member account 24/7

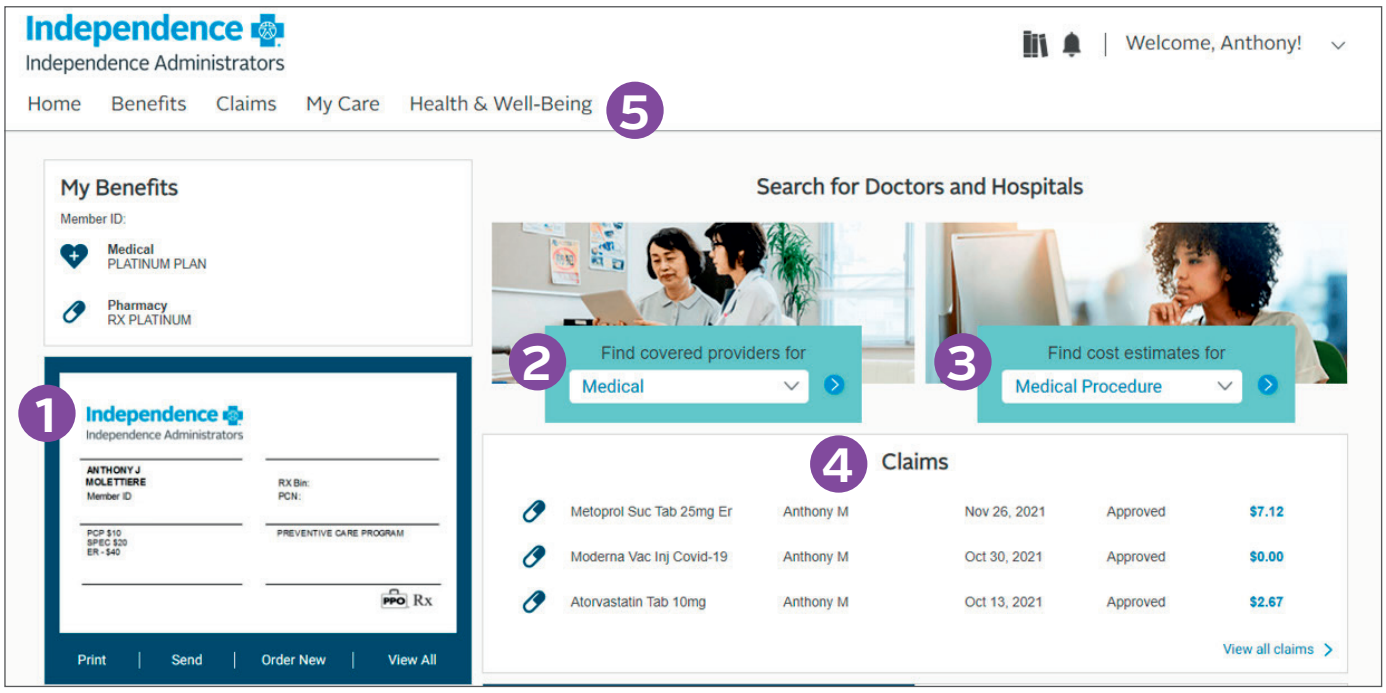
We make it easy for you to manage your health care and benefits administered by Independence Administrators. Our digital tools will guide you to the information, resources, and support you need.

It's all available when you log in to your member account at myibxtpabenefits.com or using the MyIBXTPABenefits mobile app.

If you haven't registered yet, all you need is your member ID or Social Security number. You can register for your member account after the date your benefits go into effect.

Features on the homepage

1. **ID cards**: View, share, or order your member ID card.
2. **Find in-network providers**: Search for doctors, hospitals, pharmacies, and other health care providers. Select the appropriate provider type from the drop-down menu and click the arrow to start your search.
3. **Care Cost Estimator**: Estimate what you'll pay for an office visit or procedure based on your benefits.
4. **Recent claims**: View a snapshot of your most recent claims.
5. **Main menu**: Across the top of the homepage, you can see the menu options for the site. See the next page for more about what you'll find in each section.



Independence
Independence Administrators

Navigating the menu

Benefits

Under Benefits, you can find detailed information about your benefits, including what's covered, out-of-pocket expenses, and your Benefits Booklet and Summary of Benefits & Coverage documents. You can also review your benefits usage, out-of-pocket maximum, and deductible amounts.

Claims

In this section, you can review and organize your claims. Select a specific claim to view detailed information, including an Explanation of Benefits (EOB) for claims that have been processed and approved. You can also submit a claim online, if needed.

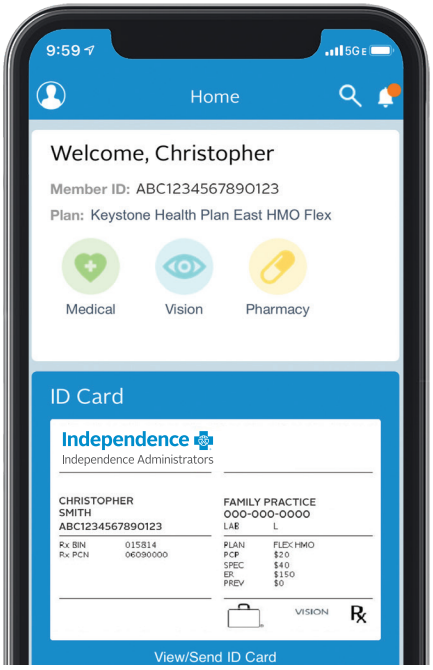
My Care

Under My Care, you can access tools and resources related to your health, such as your Personal Health Record and provider information for your favorite doctors. Your Personal Health Record shows a comprehensive view of your health and the care you have received, including health conditions, visits to the doctor, medications, lab results, and immunizations — and you can download or print your record to share with a doctor or family member.

Health & Well-Being

The Health & Well-Being section is where you can find fun, easy-to-use online tools and resources designed to help you set and reach your health and well-being goals. You can also review information about member-exclusive discounts and savings, as well as reimbursement programs to incent you to stick with healthy habits.

Log in today at myibxtpabenefits.com. Or download the free MyIBXTPABenefits app for anytime access on your iPhone or Android.



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DELTA DENTAL®

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group #1055-0001, 0002, 0003, 0099, 1001, 1002, 1003, 1099, 2001, 2002, 2003, 2099
Central Midwest Regional Council of Carpenters Welfare Fund

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.*

Control Plan – Delta Dental of Ohio

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Non-Participating Dentist
	Plan Pays	**Plan Pays**	**Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	**100%**	**100%**	**100%**
Palliative Treatment – to temporarily relieve pain	**100%**	**100%**	**100%**
Sealants – to prevent decay of permanent teeth	**100%**	**100%**	**100%**
Brush Biopsy – to detect oral cancer	**100%**	**100%**	**100%**
Radiographs – X-rays	**100%**	**100%**	**100%**
Basic Services			
Minor Restorative Services – fillings and crown repair	**80%**	**80%**	**80%**
Endodontic Services – root canals	**80%**	**80%**	**80%**
Periodontic Services – to treat gum disease	**80%**	**80%**	**80%**
Oral Surgery Services – extractions and dental surgery	**80%**	**80%**	**80%**
Other Basic Services – misc. services	**80%**	**80%**	**80%**
Relines and Repairs – to prosthetic appliances	**80%**	**80%**	**80%**
Major Services			
Major Restorative Services – crowns	**50%**	**50%**	**50%**
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	**50%**	**50%**	**50%**
Orthodontic Services			
Orthodontic Services – braces	**50%**	**50%**	**50%**
Orthodontic Age Limit –	**through age 18 and under**	**through age 18 and under**	**through age 18 and under**

* When you receive services from a Non-Participating Dentist, the percentages in this column indicate the portion of Delta Dental's Non-Participating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.

- Sealants are payable once per tooth per lifetime for first permanent molars for people age eight and under and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per Member total per Benefit Year on all services except orthodontic services. $1,500 per Member total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – Delta Dental PPO™ Dentist or Delta Dental Premier® Dentist - None.

Non-Participating Dentist - $50 Deductible per Member total per Benefit Year limited to a maximum Deductible of $100 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Waiting Period – Members are eligible for dental benefits after meeting conditions as set forth in the Central Midwest Regional Council of Carpenters Welfare Fund's Plan document.

Eligible People – All eligible members and their dependents who meet the eligibility requirements as specified by Central Midwest Regional Council of Carpenters Welfare Fund's Plan document.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which your employment is terminated.

vsp vision care

Make Eye Health a Priority with VSP!

Your health comes first with VSP and Central Midwest Regional Council of Carpenters Heath Fund. Take a look at your VSP vision care coverage.

VSP members save an annual average of

$489*

More Ways to Save

Extra $20 to spend on Featured Frame Brands†

bebe Calvin Klein COLE HAAN
DRAGON FLEXON LONGCHAMP PARIS
and more

Up to 40% Savings on lens enhancements‡

See all brands and offers at **vsp.com/offers**.

Create an account today.
Questions?
vsp.com
800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

With private practice doctors, Visionworks®, and Eyemart Express retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge

Get more at preferred in-network doctor locations

private practice doctors Visionworks EYEMART EXPRESS FAMILY OF STORES

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

†Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible. ‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details. *Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association, 2020. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

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Classification: Restricted

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through Central Midwest Regional Council of Carpenters Heath Fund.

Provider Network:
VSP Choice
Effective Date:
01/01/2026

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$15**	See frame and lenses
FRAME[+]	• $170 Featured Frame Brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $80 Costco frame allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $125 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
SAFETY GLASSES (EMPLOYEE-ONLY COVERAGE)			
SAFETY EYE EXAM	• Exam to determine safety eyewear needs	$0	Every 12 months
FRAME[+]	• $150 allowance for a safety frame • 20% savings on the amount over your allowance • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every 24 months
LENSES	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0	Every 24 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

GET MORE AT PREFERRED IN-NETWORK LOCATIONS

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor.

Cleveland Clinic

Virtual Second Opinions by Cleveland Clinic

Direct access to a Cleveland Clinic expert physician for peace of mind

67% of virtual second opinions recommend a diagnosis or treatment plan change

Cleveland Clinic 2023 outcomes data, n=300

As part of your health benefits, you have access to Cleveland Clinic's Virtual Second Opinions program. The program provides you with easy, secure access to high-quality medical expertise from the comfort of home.

Through this digital health service, you can have your medical diagnosis and treatment plan reviewed by an expert physician at Cleveland Clinic and receive an in-depth second opinion as you consider the best path forward for your health.

Cleveland Clinic supports you every step of the way. From collecting and reviewing medical records to identifying the best specialist for your needs, the program saves you time, trouble, and travel on your path to peace of mind —all at no cost to you.

What is a Virtual Second Opinion?

- A health service to have a diagnosis and treatment plan reviewed by expert physicians at Cleveland Clinic
- Personalized matching with one of 3,500 Cleveland Clinic physicians in one of over 550 advanced sub-specialties
- 100% confidential and included in your benefits package at no cost to you

We encourage you to obtain a second opinion if you are:

- Diagnosed with a serious condition
- About to make a major decision about a medical next step, such as surgery
- Considering a treatment that involves risk or has significant consequences
- Dealing with a condition or chronic illness that isn't improving or is getting worse

How it works

You register online and have a virtual intake visit with a dedicated nurse

Cleveland Clinic retrieves and reviews your medical records to match you with the best specialist

After an in-depth review, your specialist provides a detailed second opinion

Get a Virtual Second Opinion from Cleveland Clinic today

Scan the QR code to the right or follow the link below to learn more and register to get your virtual second opinion started.
Go to: clevelandclinic.org/centralmidwestcarpenters

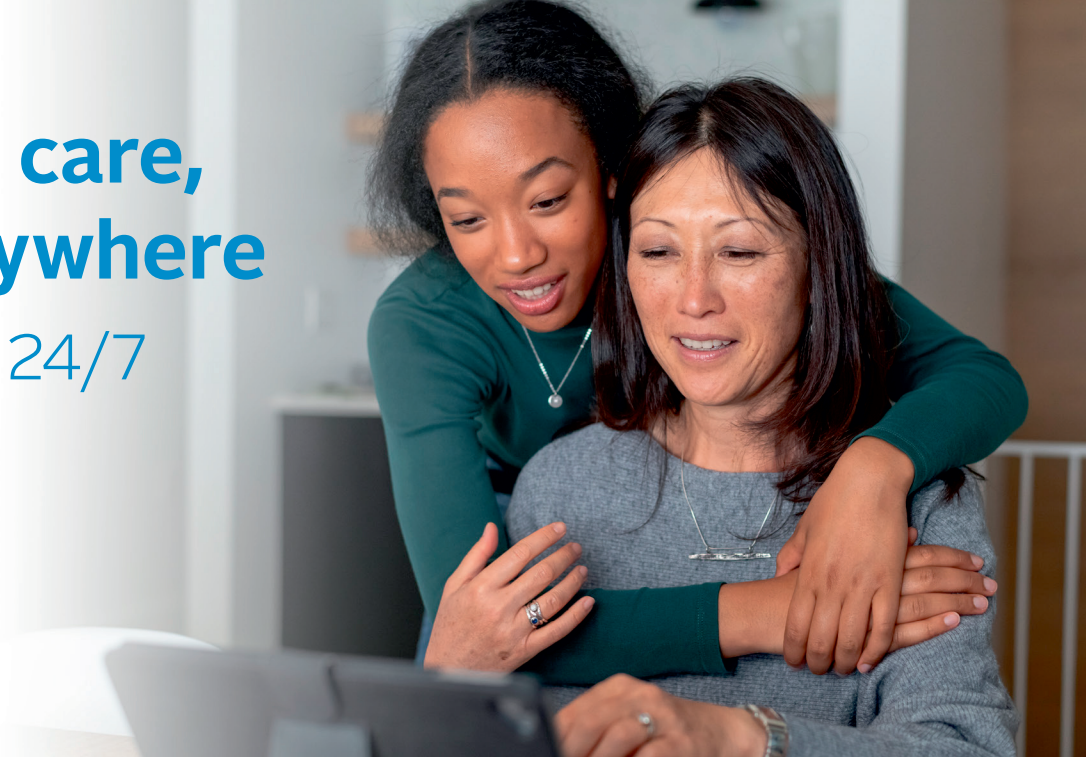
CENTRAL MIDWEST CARPENTERS
EST 1881
INDIANA · KENTUCKY · OHIO

Certain states and specialties may be limited to a written report only.

Questions? Call us at 844-777-0788 from 8:00 a.m. to 5:00 p.m. ET Monday through Friday.

Get medical care, anytime, anywhere

Talk to a doctor 24/7



When you're not feeling well, you don't want to wait to get care. Good news — with virtual care from Teladoc Health (Teladoc), you don't have to!

Teladoc is a leader in whole-person virtual care. With Teladoc General Medical, you get 24/7 access to low-cost, high-quality virtual health care for common health concerns like cough, sore throat, fever, rashes, allergies, asthma, ear infections, pink eye, nausea, and more.

Using Teladoc General Medical is quick and convenient. Features include:

- Access to one of the largest virtual care networks in the country, with board-certified doctors who are available by phone, web, or the Teladoc award-winning mobile app
- Interpreters who know your language, including American Sign Language (ASL)
- Prescription requests sent to your pharmacy of choice
- A caregiving option, which allows a babysitter to schedule a visit on your behalf if your child gets sick while in their care

Nearly 90% of users are satisfied with their Teladoc experience.

Schedule an appointment

Learn more and make an appointment at **TeladocHealth.com**.

How Teladoc General Medical works

Initiate: You can access Teladoc by:

- Calling 1-800-835-2362, or
- Visiting teladochealth.com, or
- Downloading the Teladoc mobile app

Request: Schedule a visit at your preferred time or request an on-demand visit for an urgent need.

Visit: Meet with your doctor, who will evaluate you and answer your health questions.

Resolve: Your doctor uploads a visit summary to your Teladoc file, sends any prescriptions to your pharmacy, and provides details for follow-up.

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Teladoc Health, Inc. is an independent company that provides virtual care for medical and specialty services.

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Connect with a board-certified dermatologist

Get answers to your skin care questions

If you have concerns about your skin, Teladoc Health (Teladoc) Dermatology can connect you to doctors who can diagnose your condition, recommend a treatment plan, and provide follow-up.

Teladoc Dermatology gives you access to board-certified dermatologists anywhere you are. Whether you have a question about a recent skin change or need help managing a chronic skin condition like acne, rosacea, or psoriasis, Teladoc Dermatology can help.

Using Teladoc Dermatology is quick and convenient. You get access to:

- A network of board-certified dermatologists
- An online message center where you can connect with your dermatologist
- A personalized treatment plan with follow-up care

Schedule an appointment

Learn more and make an appointment at **TeladocHealth.com**.

How Teladoc Dermatology works

Initiate: You can access Teladoc by:

- Calling 1-800-835-2362, or
- Visiting teladochealth.com, or
- Downloading the Teladoc mobile app

Inform: Complete the intake form and provide details about your skin concern.

Upload images: Upload a minimum of three digital pictures, so the dermatologist can evaluate your skin.

View online results: Within two business days, you will get a notification in the online message center from your dermatologist, with a diagnosis and treatment plan. Your dermatologist can also send any prescriptions to your pharmacy.

Follow-up: Use the online message center to communicate with your dermatologist over the next seven days. You can ask any follow-up questions or report how the condition is responding to treatment.

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Take charge of your mental well-being

Get access to convenient, confidential therapy

With Teladoc Mental Health Care, you can get trusted support for your mental and emotional health.

Teladoc Mental Health Care provides convenient, confidential access to trusted professionals who can help you manage stress, anxiety, grief, depression, and more.

Using Teladoc Mental Health Care is easy. You can:

- Find a board-certified psychiatrist, psychologist, or therapist that meets your needs
- Schedule a virtual visit by phone or video at a time that's best for you to connect
- Get ongoing support from your mental health care provider

How Teladoc Mental Health Care works

Initiate: You can access Teladoc by:

- Calling 1-800-835-2362, or
- Visiting teladochealth.com, or
- Downloading the Teladoc mobile app

Inform: Complete the intake form and provide details about your concerns.

Schedule an appointment

Learn more and make an appointment at **TeladocHealth.com**.

Schedule: Choose your mental health care provider and schedule a virtual session.

Consult: Talk to the provider about your concerns.

Support: Schedule follow-up appointments as needed.

Independence

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® Cross Blue Shield Association 65

Compassionate care for mental well-being

Teladoc Mental Health Care providers can offer support for:

- Anxiety
- Attention-deficit/hyperactivity disorder (ADHD)
- Depression
- Eating disorders
- Grief
- Obsessive-compulsive disorder (OCD)
- Panic disorder
- Post-traumatic stress disorder (PTSD)
- Stress
- Trauma resolution
- Work pressure

More than 75% of users with depression or anxiety reported improvement after their third or fourth virtual care visit.

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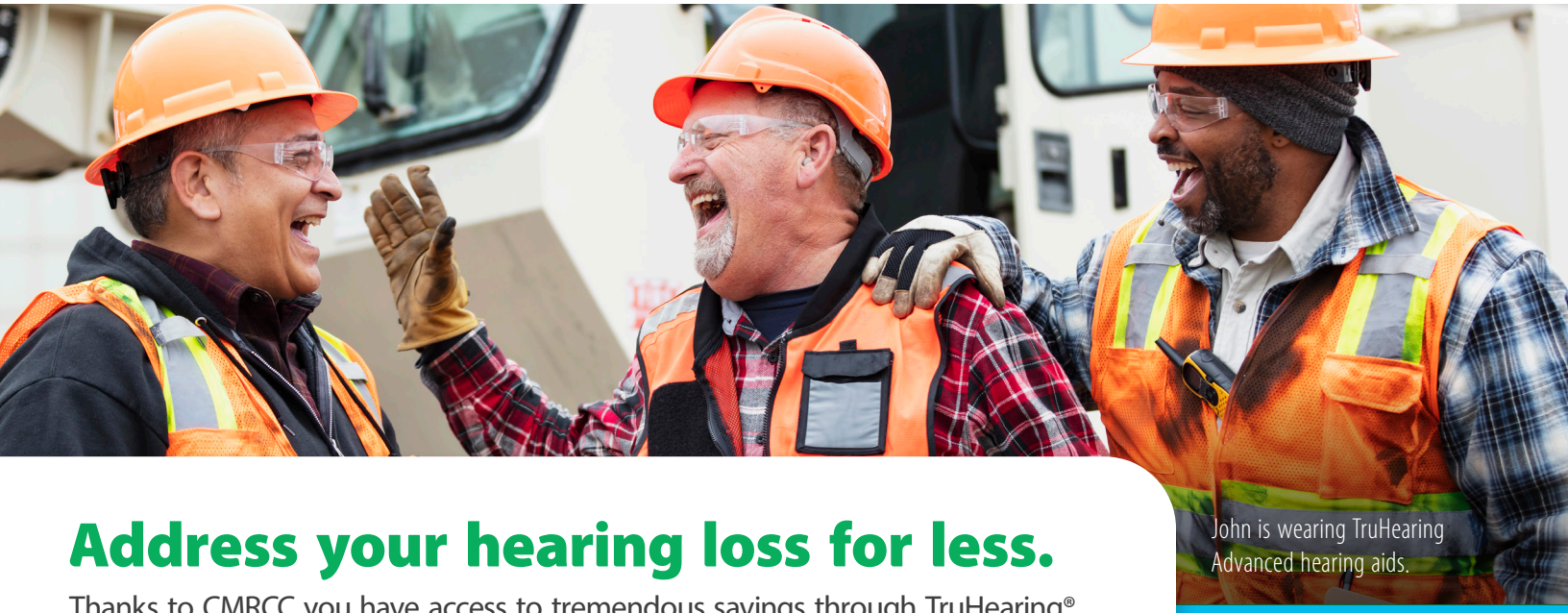
21827 2442158 (8-23)

TruHearing®

1-877-653-8876 | TTY: 711



John is wearing TruHearing Advanced hearing aids.

Address your hearing loss for less.

Thanks to CMRCC you have access to tremendous savings through TruHearing®. This benefit is provided to you through your fund, not your health insurance. This includes a hearing exam ($0 copay) and a hearing aid allowance up to $3,000 total every three years.

Hearing aid tier	Average retail price/aid	TruHearing price	**Member cost** (1 aid)	**Member cost** (2 aids)
Premium	$3,330	$1,799	**$0**	**$598**
Advanced	$2,750	$1,399	**$0**	**$0**
Standard	$2,150	$999	**$0**	**$0**
Basic	$2,000	$699	**$0**	**$0**
Value	$1,900	$499	**$0**	**$0**
TruHearing Premium	$3,250	$1,449	**$0**	**$0**
TruHearing Advanced	$2,720	$1,149	**$0**	**$0**

Exam must be performed by a TruHearing network provider.

When calling, please provide your date of birth and the last four digits of your Social Security Number to receive your maximum benefit.

Start by calling TruHearing.

1-877-653-8876 | TTY: 711

Hours: 8am–8pm, Monday–Friday

Your hearing aid purchase through TruHearing includes

60-day, risk-free trial

1 year of follow-up visits

80 free batteries per non-rechargeable hearing aid

3-year full manufacturer warranty

TruHearing makes it easy.

Get started with
5 simple steps.

1. Call
1-877-653-8876

2. Schedule
an exam

3. Go to
your exam

4. Order
hearing aids

5. Fitting and
follow-up

The right hearing aids can change your life.

Research shows that addressing hearing loss can impact your overall health and well-being, including improvements in[1]

- Mental and emotional health
- Relationship with spouse or partner
- Work performance

Call TruHearing to get started.

1-877-653-8876 | TTY: 711

Hours: 8am–8pm, Monday–Friday

Learn more: TruHearing.com/CMRCC

[1] MarkeTrak 2025.

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Central Midwest Regional Council of Carpenters' Welfare Fund
P.O. BOX 1257
TROY, MICHIGAN 48099-1257
Phone: (800) 700-6756
Email: CMRCCMRACLAIMS@benesys.com
Fax: (248) 556-2597

Medical Reimbursement Account (MRA) Claim Form

Instructions: To receive benefits from your MRA account, you must complete **ONE FORM per patient**, along with the following information:

Reimbursement for:	**Information Required:**
Medical Co-payments	Copy of your Explanation of Benefits Form (EOB). **Balance due statements are not acceptable.**
Dental and Vision Services	For actives and early retirees, a copy of your EOB. For Medicare retirees, a copy of a detailed invoice listing the services rendered and the charge for each. **Orthodontic services will be paid for after services are rendered.**
Prescription Payment or Co-Payment	For actives, early retirees and Medicare retirees, a copy of the drug label stub or a printout from your pharmacy. **Cash register receipts are not acceptable.**

PLEASE NOTE: The minimum amount that can be reimbursed must total at least $20.00 per submission. You MUST allow up to 30 business days for reimbursement.

Member's SS#

Member's Name: _____ or Alternate ID: _____

Address: _____

Phone Number: (Home) _____ (Work) _____

Patient Name: _____ Relationship: _____

Type of Service (Medical, Dental, Vision, Prescription)	**Provider Name**	**Date of Service**	**Amount of Claim** (Claims must total at least $20.00)
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

I hereby authorize payment for the above services for which I am requesting benefits:

By signing this form, I understand that benefits shall be paid in accordance with the Central Midwest Carpenters MRA Account requirements and limitations established by the Board of Trustees. (See the reverse side of this form for a brief description of covered benefits).

Member's Signature: _____ Date: _____

(OVER)

What is the MRA Account?

The Medical Reimbursement Account (MRA) is a bookkeeping account that will be established for each active eligible participant, which the participant may use to pay for deductibles and other eligible medical expenses. It is bookkeeping account only – it cannot be cashed out by participants at any time, and it does not "vest" – the Board may terminate the account at any time.

How will my (MRA) be Funded?

Each active eligible participant will have an account credited with a separate Employer Contribution. Currently, that amount is $1.00 per hour. Per the Fund's Plan document (Plan), this amount may be changed , or eliminated, as determined by the Board of trustees in their sole discretion from time to time.

What can I use the MRA account for?

The MRA may be used for all "qualified medical expenses" under Code §213 (with the exception of over-the-counter drugs, which are not eligible for reimbursement). This will include amounts you pay for qualified medical, dental, vision or prescription drug expenses which are not covered by the Fund, due to co-payments, maximum benefit allowed, or services that are not payable under the Plan, and, upon election, to pay a self-payment amount which may be due to continue your coverage. All expenses must be incurred on or after the date on which you became eligible for benefits. Please refer to your Summary Plan Description for more information.

Unfortunately, the Fund cannot provide an exhaustive list of all possible "qualified medical expenses". A partial list is provided in IRS Pub 502 (available at www.irs.gov). A determination of whether an expense is for "medical care" is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness. The determination often hangs on the word "primarily."
As an example, the following is a partial list:

- All or part of any co-payments required, or amounts in excess of usual, customary and reasonable limits, on covered medical services;
- Other medical expenses, provided they are qualified medical expenses as defined by the IRS;
- Unreimbursed dental or vision claims;
- Prescription drug co-payments;
- Diabetic education, providing you submit a prescription from your physician and obtain the education from a licensed dietitian

What expenses are not allowed?

Benefits payable under the MRA are subject to IRS rules and regulations regarding the IRS definition of qualified medical expenses which may be included in medical expense deductions. The following is a partial list of expenses not payable under the MRA. They include but are not limited to:

- Expenses already processed and the amount paid by your medical insurance carrier;
- Vitamins/Supplements (whether prescribed by a doctor or not), and over the counter drugs and supplies;
- Life Insurance Premiums and premiums for other insurance

Benefits reimbursable under the MRA are also subject to the terms and conditions of the Plan.

What do I have to do to request reimbursement from my MRA?

You must send a completed MRA Claim Form along with the following information: (NOTE: BALANCE DUE STATEMENTS ARE NOT ACCEPTABLE).

Reimbursement for:	**Information Required**
Medical Co-payments	Copy of your Explanation of Benefits Form. (EOB).
Dental and Vision Claims	For actives and early retirees, a copy of your EOB. For Medicare retirees, a complete itemized bill including date of service and explanation of service. **Orthodontic services will be paid for after services are rendered.**
Prescription Payments or Co-payments	For actives and early retirees, a copy of your EOB. For Medicare retirees, a copy of the drug label stub or a printout from your pharmacy. Cash register receipts are not acceptable.

Where do I obtain MRA Claim Forms?

You may call the Fund Office to have a Claim Form mailed to you.

Where do I send my MRA reimbursement requests?

Send these requests to:
Central Midwest Regional Council of Carpenters' Welfare Fund
P.O. BOX 1257
Troy, MI 48099-1257
Email: CMRCCMRACLAIMS@benesys.com
Fax: (248) 556-2597

Is there a time limit to file for MRA Benefits?

Yes, MRA Claims must be filed 24 months from the date the expense was incurred.

What happens to my MRA after I retire?

You will still be able to use your MRA as before. Should you die, your MRA will be transferred to your surviving spouse.

Central Midwest Regional Council of Carpenters'
Welfare Fund

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

Enhanced Member Benefit Website
CMRCCBenefits.org

Dear Member:

The Trustees of the Central Midwest Regional Council of Carpenters' Benefit Funds are pleased to announce a new combined member benefit website, CMRCCBenefits.org. This website has been fully updated to provide you with an effective way to access and manage your benefits.

The Website enables you to access benefit and personal information as well as communicate with the Benefit office and view helpful links regarding your benefits provided by the Plan.

To access your personal benefit information, such as your benefit elections, work history detail, and forms, you will need to register as a new user by clicking the *Create an Account* link at the top right-hand corner in the Login box. More detailed instructions are shown on the back of this letter. Once you are registered, you can access your personal benefit information by entering your ***User Name*** and ***Password*** (please keep these confidential). **Please note, only one *User Name* and *Password* is permitted per email address. If more than one person in your family requires website access, each must use a different email address.**

Every member, spouse, and dependent over the age of 18 will need to create their own login that will give them access to their own Protected Health Information (PHI). Each person that creates their own username and password will not have their PHI available for viewing by any other user.

Please contact the Benefit Office at (800) 700-6756 ext. 4 if you encounter any difficulty logging in or have questions regarding the Member Benefit website. You can also email the Benefit Office directly by using the "Contact Us" section of the website.

Please visit the enhanced Member Benefit website soon and see all that it has to offer!

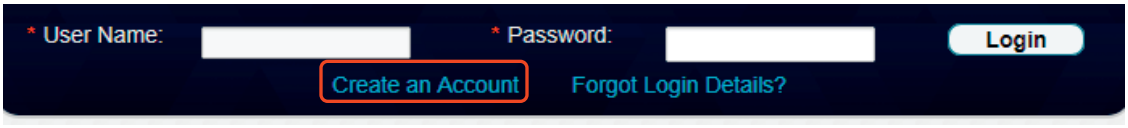
Board of Trustees,

Central Midwest Regional Council of Carpenters'
Fringe Benefit Funds

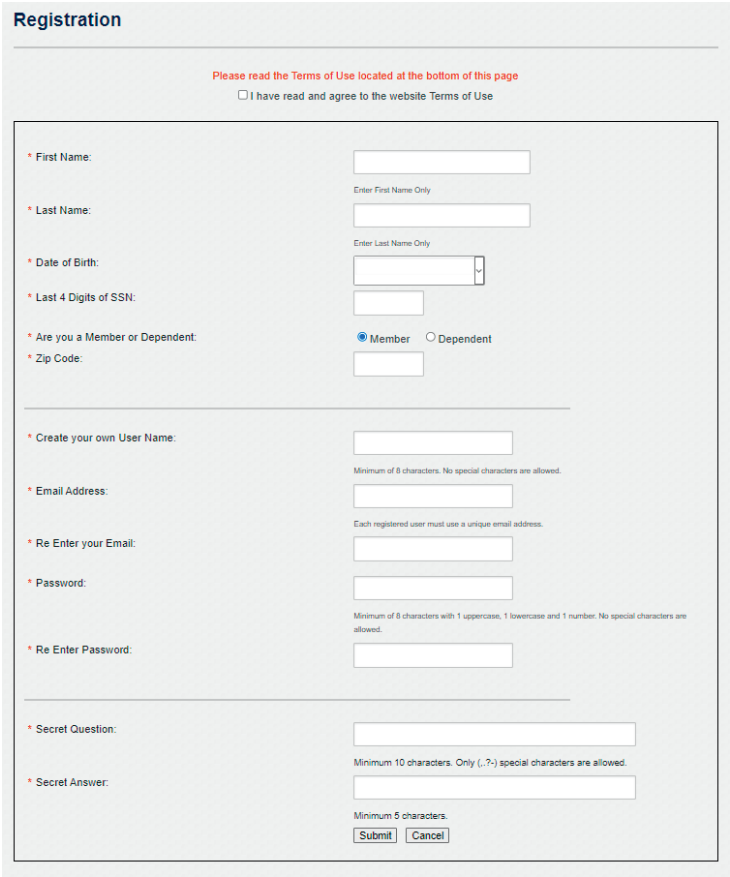
HOW TO REGISTER ON THE WEBSITE

When registering for the first time, please follow these instructions:

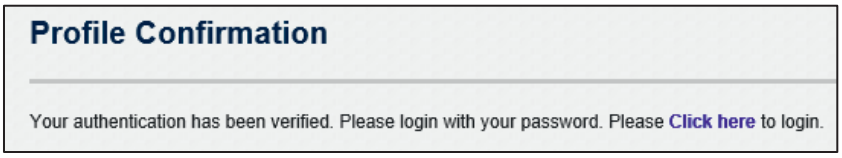
1) From your computer or mobile device, connect to the CMRCCbenefits.org website.
2) Locate the Login box in the upper right-hand corner of the screen.
3) Click on "Create an Account" to get started.



4) The Registration Screen will display next. Please enter all information, as all fields are required. Once all information has been entered, please click "Submit" on the bottom of the screen.



5) After registering you will receive an email notification with a link to confirm your registration. Your email address will also be used in the event you forget your username and password.



CMRCC BENEFIT FUNDS

Key Resources & Quick Links

Benefit Office
(800) 700-6756

Scan any QR code with your phone camera to jump straight to the website or app.
Keep this handout nearby for quick access to your benefits.

1 START HERE — Participant Website & Mobile App

CMRCC Benefits Website

www.CMRCCBenefits.org

Access: Eligibility, Pension, Annuity, Work History, Forms, Documents & FAQs

Help: (800) 700-6756

Scan to visit

CMRCC Benefits App

Search "CMRCC Benefits"

Eligibility • Pension • Work History

App Store

Google Play

2 MOST-USED — MRA Reimbursement & Retirement

MRA Account

WEX • BeneSys Reimbursement

Web: fundoffice.lh1ondemand.com

App: Search "BeneReimburse"

Call: (800) 700-6756

Scan to log in

Annuity / Retirement

John Hancock (CMRCC DC Fund)

Web: myplan.johnhancock.com

App: John Hancock Retirement

Call: 833-388-6466

Scan to register

Need help? Reach out to the Benefit Office

Reach Us
Phone: (800) 700-6756
Hours: Mon–Fri, 7:30 AM–4:30 PM ET
Online: www.CMRCCBenefits.org
Email: cmrccserviceteam@cmrccbenefits.org

Visit Us In Person
Walk-in: Mon–Fri, 8 AM–4 PM ET
Greenwood, IN: 771 Greenwood Springs Dr, 46143
Cleveland, OH: 2554 East 22nd St, 44115

Benefits administered by BeneSys, Third Party Administrator

CMRCC BENEFIT FUNDS

Health Care, Pension & Annuity Resources

Benefit Office
(800) 700-6756

3 HEALTH CARE RESOURCES

Medical
Independence Blue Cross
Web: ibx.com
Call: 833-242-3330

Telemedicine
Teladoc (with IBX)
Web: teladochealth.com
Care: Primary & urgent

Behavioral Health
IBX BH Care Navigation
Call: 844-864-4352
Crisis: Call/text 988

Prescriptions
Express Scripts
Web: express-scripts.com
Call: 800-867-4518

Weight Loss
Omada • Express Scripts
Web: omadahealth.com
Call: 800-417-1764

Dental
Delta Dental
Web: deltadentalins.com
Call: 800-867-4518

Vision
Vision Service Plan
Web: vsp.com
Call: 800-877-7195

Hearing
TruHearing
Web: truhearing.com
Call: 877-653-8876

Medical 2nd Opinion
Cleveland Clinic
Web: clevelandclinic.org
Call: 844-777-0788

Cancer Support
Cancer Navigator
Web: cancernavigator.com
Call: 317-942-9953

Diabetic Supplies
One Source
Web: d360.care
Call: 877-316-2460

Retiree Health
Humana • Retiree First
Web: humana.com
Call: 833-217-5306

4 PENSION & ANNUITY RESOURCES

Pension
Indiana State CC Pension
Ohio Carpenters Pension
SW Ohio Carpenters Pension
Web: cmrccbenefits.org
Call: 800-700-6756

Mid-America
MACRC Pension Fund
(Prior IKORCC Pension Fund)
Web: macbenefits.org
Call: 312-787-9455

Annuity / DC Fund
John Hancock
Web: myplan.johnhancock.com
Call: 833-388-6466

NW Ohio Supp.
Northwest Ohio Admin.
Web: portal.ississystems.com
For: NW OH Supp Plan participants