



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.***

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.***

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.***

*****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.



Central Midwest Regional Council of Carpenters' Fringe Benefit Funds

P.O. Box 1257, Troy, MI 48099
(800) 700-6756
ENROLLMENTDOCS@BENESYS.COM

A700

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 # _____ and Name _____
Dependent # _____

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:

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: _____



Central Midwest Regional Council of Carpenters'

Welfare Fund

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

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.

**Medicare Claim Number
including the letter(s)**

MEDICARE  **HEALTH INSURANCE**

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL (PART A) **07-01-1986**
MEDICAL (PART B) **07-01-1986**

SIGN
HERE

**DO NOT SEND CLAIMS FOR PAYMENT OF
MEDICARE BENEFITS TO THIS (↓) ADDRESS**

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.



Central Midwest Regional Council of Carpenters' Welfare Fund

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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.

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.



Central Midwest Regional Council of Carpenters'

Welfare Fund

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

- 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.
العربية Arabic	ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 (800) 700-6756
ܐܡܝܬܝܐ Assyrian	ܐܡܝܬܝܐ: ܝܐܢ ܬܚܕܝܬ ܐܢܟܪ ܐܠܬܢܐ، ܦܝܢ ܚܕܡܬ ܡܨܐܥܕܐ ܐܠܘܡܝܬܐ ܬܘܠܦܝܢ ܠܟ ܒܠܡܝܬܐܢ. ܐܬܠܥܝܬ ܒܪܦܩܡ 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 করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় 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

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.

The screenshot shows the Independence Administrators member homepage. At the top, the logo and navigation menu are visible. The main content area is divided into several sections. On the left, the 'My Benefits' section displays the member ID and plan details. Below this is a large card for the member ID card, which includes the member's name, ID number, and plan details. On the right, there are two search bars for finding providers and cost estimates. Below these is a 'Claims' section showing a list of recent claims with details like medication, date, and status. The numbered callouts highlight the following features:

- 1** ID cards: View, share, or order your member ID card.
- 2** Find covered providers for: Search for doctors, hospitals, pharmacies, and other health care providers.
- 3** Find cost estimates for: Estimate what you'll pay for an office visit or procedure based on your benefits.
- 4** 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.

Medication	Member	Date	Status	Amount
Metoprol Suc Tab 25mg Er	Anthony M	Nov 26, 2021	Approved	\$7.12
Moderna Vac Inj Covid-19	Anthony M	Oct 30, 2021	Approved	\$0.00
Atorvastatin Tab 10mg	Anthony M	Oct 13, 2021	Approved	\$2.67

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.

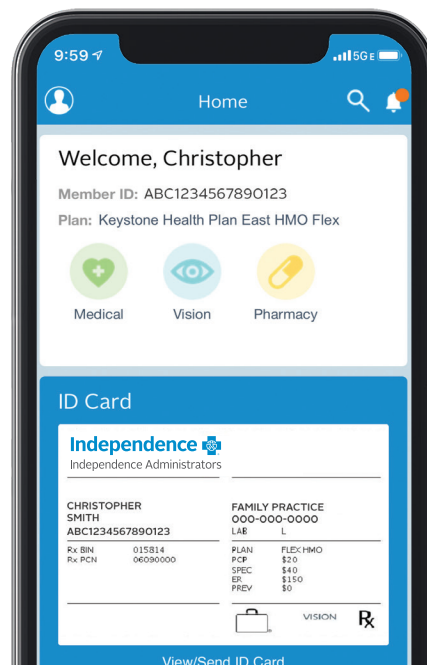


Health & Well-Being

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.



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.

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

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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.

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

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

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

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

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Schedule an appointment

Learn more and make an appointment at
[TeladocHealth.com](https://www.teladochealth.com).

How Teladoc Dermatology works



Initiate: You can access Teladoc by:

- Calling 1-800-835-2362, or
- Visiting [teladochealth.com](https://www.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.

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.

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.

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

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




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 ?	<p>In-Network*: \$1,750/individual / \$3,500/family</p> <p>Out-of-Network: \$3,500/individual / \$7,000/family</p> <p>*Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.</p>	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 ?	In-Network Wellness & Preventive Services and Teladoc Doctor Visit 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 in-network 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	<p>In-Network*: – \$7,350/individual / \$14,700/family</p> <p>Out-of-Network: \$10,000/individual / \$20,000/family</p> <p>*Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.</p>	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 ?	Premiums , balance billing charges, non-network cost sharing , health care this plan doesn't cover, charges in excess of reasonable and customary and penalties for failing to obtain preauthorization for services.	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	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network not subject to deductible . Teladoc Program - no copayment , deductible or coinsurance . Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
	Specialist visit	\$40 copayment /visit		In-network not subject to deductible .
	Preventive care/screening/ Immunization	No charge	Not covered	Coverage available in-network only. Immunizations available from any allowed providers , including pharmacies. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance after deductible	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	-----none-----
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition	Generic drugs	Not covered		-----none-----
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after deductible	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	-----none-----
	Physician/surgeon fees			

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 25% coinsurance after deductible	\$250 copayment /visit, then 25% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Copayment waived if patient is admitted to the hospital or if visit is due to an injury or life-threatening event.
	Emergency medical transportation	25% coinsurance after deductible	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	-----none-----
	Urgent care	25% coinsurance after deductible	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network not subject to deductible . Teladoc Program - no copayment , deductible or coinsurance . Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after deductible	45% 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. Precertification required.
	Physician/surgeon fees			-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In office physician visit: subject to \$20 copayment /visit only 25% coinsurance after deductible for all other outpatient services.	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network in office physician visit not subject to deductible . Teladoc Program – no copayment , deductible or coinsurance . Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
	Inpatient services	25% coinsurance after deductible		Residential Treatment Facility must be an in-network facility and is limited to 60 days per calendar year. Precertification required.
If you are pregnant	Office visits	25% coinsurance after deductible	45% 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). Maternity care of a dependent child is covered. Newborn care of a newborn of a dependent child is not covered. Cost sharing does not apply for preventive services . Depending on the type of services, coinsurance or a deductible may apply.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			Inpatient stay of at least 48 hours (vaginal delivery) or at least 96 hours (cesarean section delivery). Maternity care of a dependent child is covered. Newborn care of a newborn of a dependent child is not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance after deductible	45% coinsurance unless otherwise required by No Surprises Act	Coverage is limited to 40 days max per year combined in and out-of-network providers .
	Rehabilitation services			-----none-----
	Habilitation services			
	Skilled nursing care		Not covered	Prior authorization required. Limit 60 days per calendar year.
	Durable medical equipment		45% coinsurance unless otherwise required by No Surprises Act	Includes rental fees not to exceed the purchase price. Must meet medically necessary requirements.
	Hospice services			Services can be provided through a freestanding hospice facility or a hospice program sponsored by a hospital or home health care agency or at a private residence.
If your child needs dental or eye care	Children’s eye exam	No charge for children up to age 19		Limited to once every 12 months.
	Children’s glasses	No charge for medically necessary services for children up to age 19		Limited to once every 24 months.
	Children’s dental check-up	No charge for preventive services up to age 19		Cleanings and exams limited to two per year. Preventive dental services are not subject to dental deductible .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services and limitations of coverage.)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery (unless medically necessary) Dental care (adult) 	<ul style="list-style-type: none"> Hearing aids Infertility treatment Long-term care 	<ul style="list-style-type: none"> Prescription drugs Routine eye care (adult) Routine foot care Weight loss programs
Other Covered Services (Limitations may apply to these and other covered services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Bariatric surgery (if Plan guidelines are met) Chiropractic care (25 visits per year) 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. (see www.bcbsglobalcore.com) 	<ul style="list-style-type: none"> Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Fund Office at (855) 837-3528 or the Department of Labor's Employee Benefits Security Administration at (866) EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Para obtener asistencia en Español, llame al (855) 837-3528.

Dutch (Deutsch): Fer Hilf grieve in Deutsch, ruf (855) 837-3528 uff.

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$1,750
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$2,700
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$4,520

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,750
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$3,500
The total Joe would pay is	\$4,600

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,750
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,750
Copayments	\$100
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$2,060

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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

The Clinic 2023 outcomes data, n=300

Through Central Midwest Regional Council of Carpenters Welfare Fund, you have access to The Clinic by 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.

The 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



The 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: www.clinicbyclevelandclinic.com/central-midwest-carpenters





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!

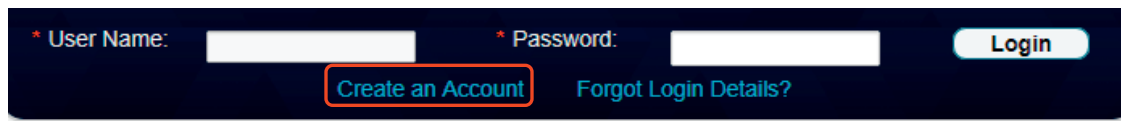
Board of Trustees,

Central Midwest Regional Council of Carpenters'
Fringe Benefit Funds

HOW TO REGISTER ON THE WEBSITE

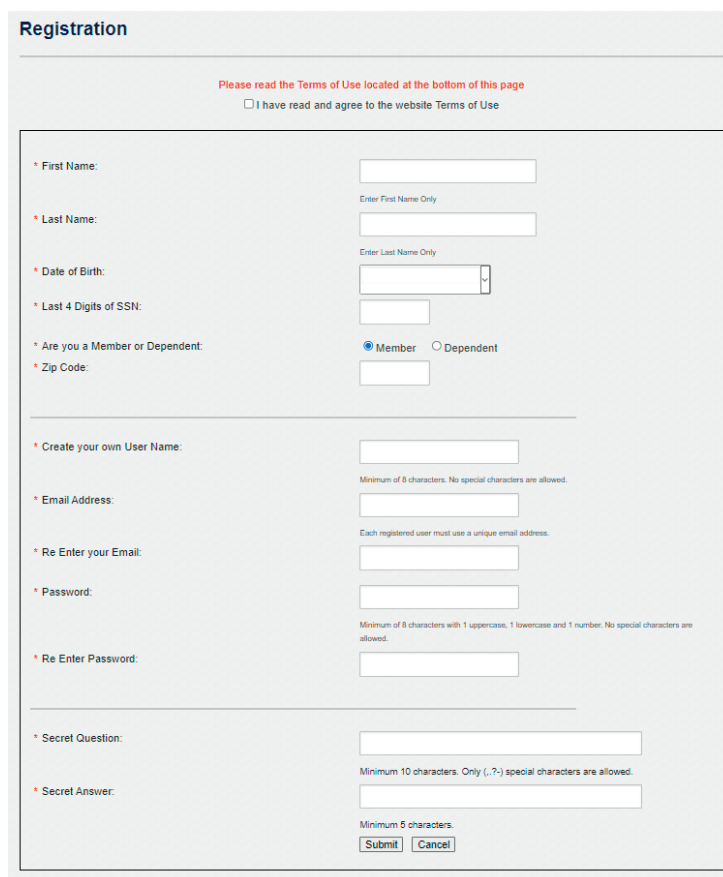
When registering for the first time, please follow these instructions:

- 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.



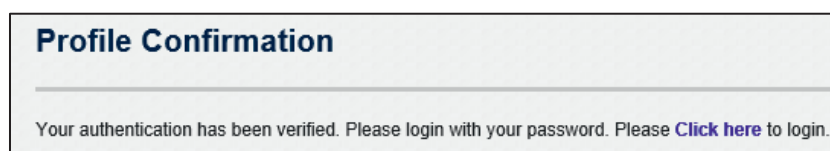
A dark blue horizontal bar containing login and registration options. On the left, there is a label '* User Name:' followed by a white text input field. To its right is a label '* Password:' followed by another white text input field. On the far right is a white button with the text 'Login'. Below the 'User Name' field is a blue button with a red border labeled 'Create an Account'. To the right of this button is a blue link labeled 'Forgot Login Details?'.

- 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.



The registration form is titled 'Registration' in bold blue text. Below the title is a red text prompt: 'Please read the Terms of Use located at the bottom of this page'. Underneath this is a checkbox labeled 'I have read and agree to the website Terms of Use'. The form is divided into two main sections. The first section contains fields for: '* First Name:' (with a hint 'Enter First Name Only'), '* Last Name:' (with a hint 'Enter Last Name Only'), '* Date of Birth:' (a date picker), '* Last 4 Digits of SSN:', '* Are you a Member or Dependent:' (with radio buttons for 'Member' and 'Dependent'), and '* Zip Code:'. The second section contains fields for: '* Create your own User Name:' (with a hint 'Minimum of 8 characters. No special characters are allowed.'), '* Email Address:' (with a hint 'Each registered user must use a unique email address.'), '* Re Enter your Email:', '* Password:' (with a hint 'Minimum of 8 characters with 1 uppercase, 1 lowercase and 1 number. No special characters are allowed.'), and '* Re Enter Password:'. At the bottom of the form are fields for '* Secret Question:' and '* Secret Answer:' (with a hint 'Minimum 10 characters. Only (. ? -) special characters are allowed.'), followed by a hint 'Minimum 5 characters.' and two buttons: 'Submit' and 'Cancel'.

- 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.



A box titled 'Profile Confirmation' in bold blue text. Below the title is a message: 'Your authentication has been verified. Please login with your password. Please [Click here](#) to login.'