Ohio Carpenters' Fringe Benefit Funds
Health Fund: P.O. Box 1257, Troy, MI 48099
Pension and Annuity Funds: P.O. Box 31580, Independence, OH 44131
Phone: (248) 641-4967 Toll Free: (855) 837-3528 Fax: (216) 539-3221
Website: www.ocbenefits.org

February 2023

To: All Participants of the Ohio Carpenters Health Plan

From: Board of Trustees of the Ohio Carpenters Health Plan

Effective January 1, 2023, Independence Blue Cross (Independence) replaced Anthem Blue Cross as your medical network provider, and medical claims are now paid by Independence Administrators (IA) instead of BeneSys.

This notice serves as a reminder of certain information previously distributed, and also provides additional information clarifying how certain benefits will be handled as a result of the 1/1/23 transition. Please keep this notice as an update to your 1/1/23 Summary of Benefits and Coverage (SBC) and Summary Plan Description (SPD).

YOUR BENEFITS AND DOCTORS

- The same doctors and hospitals are in-network with Independence and Anthem so you may continue to use the same doctors and providers, and none of the benefits offered by the Fund are changing.
- Your copayments, deductibles, and other coverages are not changing.
- There is information set forth below regarding telemedicine, hearing aid benefits, diabetic testing supplies, and payment of out-of-network claims. Please read carefully.

TELEMEDICINE

Effective January 1, 2023, telehealth video visits are available through MDLive, instead of LiveHealth Online. You may use MDLive by visiting this website: **mdlive.com/ibxtpa.** There is no cost to you to use MDLive.

HEARING AID BENEFITS

Hearing aid benefits are self-insured and will still be processed by BeneSys. **All claims for hearing aid benefits must be submitted to BeneSys at P.O Box 1257, Troy, MI 48099-1257.** If you have any questions about this benefit, contact BeneSys at (855)-837-3528.

DIABETIC TESTING SUPPLIES

OneHealth is a comprehensive program that provides certain diabetic testing supplies at no cost to you. A list of covered diabetic test supplies is available at BeneSys, and includes blood glucose monitors, test strips, lancets, alcohol prep pads, blood ketone test strips, and insulin pumps. If you have any questions about this benefit, you may contact OneSource at 877-316-2460/ www.D360.care or BeneSys at (855)-837-3528.

You are not required to use OneHealth for your diabetic testing supplies. However, if you do not receive your supplies through OneHealth or the Fund's Prescription Drug Program, you may have to pay the applicable cost-sharing amounts (co-payments, etc.) for testing supplies set forth in the Plan. The Fund currently covers diabetic testing supplies in-network at 75%.

PRECERTIFICATION

Prior to 1/1/2023, precertification of benefits was provided by American Health Holdings (AHH). Effective 1/1/2023, precertification will be performed by Independence Administrators. Please refer to your SPD for a list of benefits that require precertification. This is a service normally performed by your doctor, however if you have any questions, you may contact Independence Administrators at 1-833-242-3330 or BeneSys at (855)-837-3528.

OUT-OF-NETWORK RATE

Prior to 1/1/23, the amount paid by the Plan for out-of-network claims was 55% of the amount determined to be "Reasonable and Customary." "Reasonable and Customary," in general, is the amount charged by most providers providing like services in the geographic area where the services are rendered.

As a result of the transition to Independence, out-of-network claims will now be paid by the Plan based on Medicare Rates:

- For professional procedures, the Plan will pay 100% of the applicable Medicare rate.
- For institutional procedures, the Plan will pay 150% of the applicable Medicare rate.
- Where there is no Medicare rate available, the Plan will pay 50% of actual charges.

Any balance owed to an out-of-network provider after the Plan makes payment remains your responsibility – this is known as balance billing (subject to exceptions, such as Emergencies for which you cannot be balance billed). Therefore, we encourage you to use in-network providers to save costs for yourself and the Plan.

ID CARDS

You will be receiving a new prescription drug card to present at the pharmacy when picking up your medications. This card is separate and apart from your medical insurance card reflecting Independence as your new medical network.

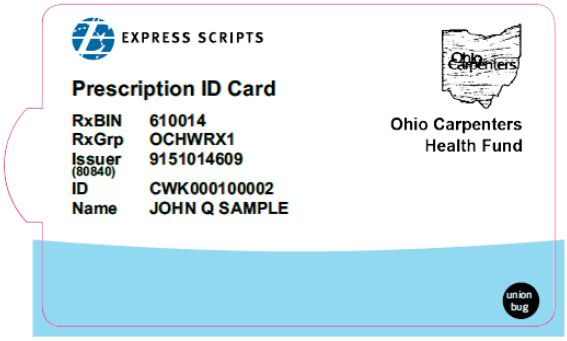
As a reminder, you should have already received your new ID Card for your medical coverage with Independence.

For your convenience, we have provided images of what all your ID Cards should look like:

Independence Medical ID Card

Dental/Vision ID Card – Do Not Discard

Prescription Drug ID Card – Do Not Discard



If you have any questions, please contact BeneSys at: (855)-837-3528.

IMPORTANT PHONE NUMBERS

Here is a list of important phone numbers for use after January 1, 2023:

Medical Claims: Contact Independence Administrators (IA) at 1-833-242-3330

All Benefit Questions
Other than Medical: Contact BeneSys at 855-837-3528.

Eligibility: Contact BeneSys at 855-837-3528.

If you have any questions, please contact the Fund Office at (855)-837-3528.

W2616084

Ohio Carpenters' Fringe Benefit Funds
Health Fund: P.O. Box 1257, Troy, MI 48099
Pension and Annuity Funds: P.O. Box 31580, Independence, OH 44131
Phone: (248) 641-4967 Toll Free: (855) 837-3528 Fax: (216) 539-3221
Website: www.ocbenefits.org

July 2023

To: **All Participants of the Ohio Carpenters Health Plan**

From: **Board of Trustees of the Ohio Carpenters Health Plan**

Please read this Notice carefully. It contains important information about changes to the Ohio Carpenters Health Plan (Plan). Please keep this notice with your Ohio Carpenters Health Fund Summary Plan Description (SPD). The changes set forth in this notice are effective January 1, 2023, unless otherwise indicated below.

1. OUT-OF-NETWORK RATE

As you know, effective January 1, 2023, Independence Blue Cross (Independence) replaced Anthem Blue Cross as your medical network provider, and medical claims are now paid by Independence Administrators (IA) instead of BeneSys. This notice clarifies how the Plan pays claims from out-of-network providers and facilities effective 1/1/23.

Prior to 1/1/23, the amount paid by the Plan for out-of-network claims was 55% of the amount determined to be "Reasonable and Customary." "Reasonable and Customary," in general, is the amount charged by most providers providing like services in the geographic area where the services are rendered.

As a result of the transition to Independence, out-of-network claims are now paid based on Medicare Rates instead of "Reasonable and Customary" amounts, as follows:

- For institutional procedures, the Plan will pay 55% of 150% of the applicable Medicare rate.
- For professional procedures, the Plan will pay 55% of 100% of the applicable Medicare rate.
- Where there is no Medicare rate available, the Plan will pay 55% of 50% of actual charges.

For example:

- The Plan receives an out of network charge of $1,000 for a non-emergency elective institutional procedure and the applicable Medicare Rate is $500. Assuming the deductible is met, the Plan will pay $412.50, calculated as follows: 55% multiplied by $750 (150% of $500.00) = $412.50.

- The participant is responsible to pay 40% of the approved charge, which is $337.50 (45% of $750).

- The participant may also be responsible for any additional balance billing assessed by the provider, which in this example would be another $250 - the original charge of $1,000 less $412.50 paid by the Plan and the $337.50 co-insurance paid by the participant leaves a $250 balance.

As seen in this example, any balance owed to an out-of-network provider after the Plan makes payment remains the participant's responsibility – this is known as balance billing (subject to exceptions, such as Emergencies for which you cannot be balance billed). **Therefore, we encourage you to use in-network providers to save costs for yourself and the Plan.**

2. EXPIRATION OF EXTENDED PLAN DEADLINES

Due to the National Emergency, beginning March 1, 2020, the deadlines below were extended until the earlier of either

(1) one year from the individual's original deadline as stated in the Plan; or (2) 60 days after the announced end of the National Emergency as declared by the President (referred to as the Outbreak Period). This deadline extension applied to these calculations:

- The COBRA election period;
- Timely payment of COBRA premiums;
- Timely notice from covered person of a COBRA qualifying event;
- Timely notice from the plan to a covered person that they may elect COBRA;
- Timely election of HIPAA Special Enrollment rights;
- Timely filing of claims;
- Timely filing of appeals; and
- Timely filing of requests for external review.

The National Emergency ended on May 11, 2023, and therefore the above extended deadlines will expire on July 10, 2023 (i.e., the end of the Outbreak Period mentioned above). Without these extended deadlines, the deadlines in the Plan will revert to those in place before the National Emergency, i.e. the Plan deadlines set forth in the Plan.

3. CHANGES TO APPEAL PROCESS EFFECTIVE JANUARY 1, 2023

Effective January 1, 2023, all appeals should be submitted directly to Independence Administrators at: Independence Administrators, Appeals Department, PO Box 21974, Eagan, MN 55121. You will soon be receiving a new Summary Plan Description detailing the Appeals Process.

4. COVERAGE FOR AUTISM SPECTRUM DISORDER (ASD) AND ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER (ADHD)

Effective January 1, 2023, the Plan will provide coverage for treatment and services related to ASD and ADHD. Please be advised that all exclusions listed in the Plan document still apply.

5. CHANGES TO ORTHODONTIC BENEFIT

Effective January 1, 2023, the lifetime treatment limit for Class IV orthodontics has increased from $1,000 to $1,500.

6. CHANGES TO CORONAVIRUS/COVID-19 BENEFITS EFFECTIVE MARCH 14, 2023

Effective March 14, 2023, the Plan changed how it covers treatment and testing of COVID-19.

COVID-19 TESTING

The Plan will no longer cover COVID-19 Testing at 100% for both in and out-of-network. Coverage for COVID-19 Testing is now covered as follows:

Medical Benefits	In-Network	Out-Of-Network
COVID-19 testing	75% after deductible	55% of Applicable Medicare Rate after deductible

TREATMENT OF COVID-19

Treatment of COVID-19 will no longer be covered In-Network at 100%. Treatment of COVID-19 is now covered as follows:

Medical Benefits	In-Network	Out-Of-Network
Treatment for COVID-19 (this does not include Long- or Post-COVID-19)	75% after deductible	55% of Applicable Medicare Care Rate after deductible

OTC COVID-19 TESTS

The Plan will continue to cover FDA approved OTC COVID-19 Tests purchased for person use (e.g., not for employment purposes or resale) through December 31, 2023 as follows:

Medical Benefits	In-Network	Out-Of-Network
OTC COVID-19 Testing – FDA approved tests purchased on or after January 15, 2022 through December 31, 2023, for personal use (e.g., not for employment purposes or resale) Maximum 8 tests per 30 day period per covered person Note: OTC COVID-19 tests covered via Pharmacy Benefit Manager.	100% coverage at retail and via direct to consumer shipping options provided by Pharmacy Benefit Manager	55% of Applicable Medicare Rate after deductible

OTC COVID-19 Tests purchased after December 31, 2023, will be covered via normal cost sharing as set forth in the Plan.

7. CHANGES TO EXCLUSION FOR GENDER DYSPHORIA

Currently, the Plan excludes coverage for "Transexual or Transgender surgery or any treatment leading to or in connection with transsexual or transgender surgery.

Effective June 30, 2023, the Plan's exclusion has been revised to exclude coverage for all services, items, conditions, or expenditures relating to "Gender Dysphoria (e.g. (e.g., transexual or transgender surgery, sex transformation, gender reassignment, and any treatment leading to or in connection with transsexual or transgender surgery). This exclusion includes all medications, implants, surgery, medical or psychiatric treatment, both pre- and post-operative care, and related hormone treatments.

8. CHANGES TO COVERAGE RELATING TO INFERTILITY

The Plan excludes coverage for "Artificial insemination, in vitro fertilization, embryo transfer procedures, or other procedures related to the treatment of infertility." However, the Fund currently covers procedures related to the diagnosis of infertility.

Effective November 29, 2022, the Fund will also cover genetic testing used to diagnose infertility.

9. IMPORTANT PHONE NUMBERS

As a reminder, here is a list of important phone numbers:

Medical Benefit Questions For Active Participants/Non-Medicare Retirees/Shop Employees:
Contact Independence Administrators (IA) at 1-833-242-3330.

Medical Benefit Questions For Retirees Enrolled in the Humana Medicare Advantage Plan:
Contact Labor First at 216-260-0988.

All Other Benefit Questions:
Contact BeneSys at 855-837-3528.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE FUND OFFICE AT (855) 837-3528.

W2636402v2

Ohio Carpenters' Fringe Benefit Funds
Health Fund: P.O. Box 1257, Troy, MI 48099
Pension and Annuity Funds: P.O. Box 31580, Independence, OH 44131
Phone: (248) 641-4967 Toll Free: (855) 837-3528 Fax: (216) 539-3221
Website: www.ocbenefits.org

November 2023

To: All Participants of the Ohio Carpenters Health Plan

From: Board of Trustees of the Ohio Carpenters Health Plan

Please read this Notice carefully. It contains important information about changes to the Ohio Carpenters Health Plan (Plan). Please keep this notice with your Ohio Carpenters Health Fund Summary Plan Description (SPD).

1. CHANGES TO APPEAL PROCESS FOR MEDICAL CLAIMS EFFECTIVE JANUARY 1, 2023

With the switch to Independence Administrators, the appeals process for medical benefits also changed. As of January 1, 2023, all medical appeals have been handled by Independence Administrators or an External Review Organization (ERO), where applicable.

Effective January 1, 2024, the procedure will be modified, as summarized below:

- There are two types of appeals: Complaints and Grievances.
- Grievances are appeals arising from the denial of claims for lack of "medical necessity." (To be covered by the Plan, all services received must be medically necessary, as defined by the Plan. A claim is denied if it does not meet this standard.)
- Complaints are all other appeals. This would include claims denied for lack of eligibility, plan exclusions, etc.
- For both Grievances and Complaints, there are two levels of appeal, as follows:
    - Grievances (i.e., claims denied for lack of Medical Necessity)
        - First level appeals must be filed within 180 days of the claim denial and sent to Independence Administrators, Appeals Department, PO Box 21974, Eagan, MN 55121. Instructions for filing a first level appeal will be included on a participant's Explanation of Benefits (EOB).
        - If Independence denies the first level appeal, a second level appeal may be submitted to an External Review Organization (ERO). When a participant receives a first level denial from Independence, it will include instructions on how to file a second level appeal with an ERO. Second level appeals must be filed within 180 days of the first level appeal denial.

- If the ERO denies your appeal, you will have the right to bring a civil action under ERISA within 180 days of the ERO appeal denial. Independence Administrators will send a letter confirming the ERO decision and providing further information on the right to bring a civil suit, as applicable.

- Complaints (Claims denied for reasons other than lack of Medical Necessity)

  - First level appeals must be filed within 180 days of the claim denial and sent to Independence Administrators, Appeals Department, PO Box 21974, Eagan, MN 55121. Instructions for filing a first level appeal will be included on a participant's Explanation of Benefits (EOB).

  - If Independence denies the first level appeal, a second level appeal may be submitted to the Board of Trustees of the Ohio Carpenters' Health Fund, c/o BeneSys Inc., 700 Tower Drive., Suite 300, Troy, MI 48098. Second level appeals must be filed within 60 days of the first level appeal denial.

  - If the Board of Trustees denies the second level appeal, a participant will have the right to bring a civil action under ERISA within 180 days of the Board's appeal denial. A participant will receive a letter from the Fund Office, on behalf of the Board, explaining its decision on appeal and the right to bring a civil suit, as applicable.

2. PRECERTIFICATION REQUIREMENTS EFFECTIVE JANUARY 1, 2023

Under the terms of the Plan, certain hospital admissions and procedures must be reviewed prior to delivery to ensure medical necessity and other requirements of coverage are met. This is known as "precertification."

Normally, the precertification process is handled by your prescribing physician. However, it is ultimately your responsibility to ensure that precertification occurs.

Attached to this notice please find the current list of items or services that must be precertified under the terms of the Plan.

If precertification is denied, you may appeal that decision as set forth above.

3. SWITCH FROM MDLIVE TO TELADOC FOR TELEMEDICINE SERVICES EFFECTIVE JANUARY 1, 2024

Effective January 1, 2024, Teladoc will replace MDLive as the Fund's telemedicine provider. Teladoc is a program that allows Covered Persons to contact a Physician online (with a webcam) or through a smartphone 24 hours a day, 7 days a week, for non-emergency issues. Teladoc is accessible at www.TeladocHealth.com or via telephone at: 1-800-835-2362. Visits through Teladoc are covered 100% (in-network only).

4. COVERAGE FOR WEIGHT LOSS DRUGS EFFECTIVE DECEMBER 1, 2023

Certain weight loss drugs are covered under the Plan's Prescription Drug Program. There are different criteria that must be met to obtain coverage, depending on the drug prescribed. In general, the following criteria must be met to be approved for coverage initially:

(1) At least 18 years of age; and
(2) Engage in behavioral modification and a reduced-calorie diet (may be required prior to starting drug coverage); and
(3) Have a Body Mass Index (BMI):
    - Equal or greater than 30; or
    - Equal or greater than 27 and at least one of the following risk factors:
        - Type 2 diabetes;
        - Hypertension;
        - Dyslipidemia;
        - Obstructive sleep apnea, or
        - Cardiovascular disease.

For more information, please contact the Fund Office at: 855-837-3528.

5. IMPORTANT PHONE NUMBERS

As a reminder, here is a list of important phone numbers:

Medical Claims:	Contact Independence Administrators (IA) at 1-833-242-3330
All Benefit Questions Other than Medical:	Contact BeneSys at 855-837-3528.
Eligibility:	Contact BeneSys at 855-837-3528.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE FUND OFFICE AT (855)-837-3528.

Services that require precertification

Core Precertification List Effective: 7/1/2023

This applies to services performed on an elective, non-emergency basis. Because a service or item is subject to precertification, it does not guarantee coverage. The terms and conditions of your benefit plan must be reviewed to determine if any of these services or items are excluded. For your reference, we have published a list of medical codes for services that require precertification, which is available on our Medical Policy Portal.Some services or supplies in this list may not be covered by your benefits plan. Please check your benefit plan documents.

Inpatient services

- Acute rehabilitation admissions
- Elective surgical and nonsurgical inpatient admissions
- Elective inpatient hospital-to-hospital transfers
- Inpatient hospice admissions
- Long term acute care (LTAC) facility admissions
- Skilled nursing facility admissions

Procedures

- Obesity surgery

Reconstructive procedures and potentially cosmetic procedures

- Blepharoplasty/blepharoptosis repair
- Bone graft, genioplasty, and mentoplasty
- Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
- Canthopexy/canthoplasty
- Cervicoplasty
- Chemical peels
- Dermabrasion
- Excision of subcutaneous skin and/or subcutaneous tissue
- Gender reassignment surgery
- Genetically and bioengineered skin substitutes for wound care
- Hair transplants
- Injectable dermal fillers
- Keloid removal
- Lipectomy, liposuction, or any other excess fat removal procedure
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Scar revision
- Skin closures including:
  - Skin grafts
  - Skin flaps
  - Tissue grafts
- Surgery for varicose veins, including perforators and sclerotherapy

Experimental or investigational

Any procedure, device, or service that may be considered experimental or investigational including:

- New emerging technology/procedures, as well as existing technology and procedures applied for new uses and treatments

Day rehabilitation programs

Elective (nonemergency) ground, air, and sea ambulance transportation, including inpatient hospital-to-to hospital transfers

Outpatient private-duty nursing

Home-Care Services

- Enteral feeding therapy (tube feeding)
- Home health care
- Home infusion therapy
- Hospice

Prosthetics/orthoses

- Custom ankle-foot orthoses
- Custom knee-ankle-foot orthoses
- Custom knee braces
- Custom limb prosthetics including accessories/ components
- Repair or replacement of all prosthetics/orthoses that require precertification

Select Durable medical equipment (DME)

- Bone growth stimulators
  - Low intensity ultrasound noninvasive bone growth stimulation
  - Other than spinal noninvasive electrical bone growth stimulation
- Bone-anchored (osseointegrated) hearing aids
  - Bone conduction hearing aids
  - Cochlear implants
- Dynamic adjustable and static progressive stretching devices (excludes CPMs)
- Electric, power, and motorized wheelchairs including custom accessories
- Insulin pumps
- Manual wheelchairs with the exception of those that are rented
- Negative pressure wound therapy
- Neuromuscular stimulators
- Power operated vehicles (POV)
- Pressure reducing support surfaces including:
  - Air fluidized bed
  - Non-powered advanced pressure reducing mattress
  - Powered air flotation bed (low air loss therapy)
  - Powered pressure reducing mattress
- Push rim activated power assist devices
- Repair or replacement of all DME items that require precertification

- Speech generating devices

Medical foods

Hyperbaric oxygen therapy

Transplants

All transplant procedures, with the exception of corneal transplants

Mental health/serious mental illness/ substance abuse

- Mental health and serious mental illness treatment (inpatient/partial hospitalization programs/intensive outpatient programs)
- Repetitive transcranial magnetic stimulation (rTMS)
- Substance abuse treatment (inpatient/partial hospitalization programs/intensive outpatient programs)

Autism spectrum disorders

Applied behavioral analysis

Specialty drugs that require precertification

All listed brands and their generic equivalents or biosimilars require precertification. This list is subject to change.

Amyotrophic Lateral Sclerosis agents

- Qalsody ™ (tofersen)
- Radicava™ (ravulizumab)

Antineoplastic agents/Chemotherapy

- Abraxane® (paclitaxel protein-bound particles)
- Adcetris® (brentuximab vedotin)
- Adstiladrin® (nadofaragene firadenovec)
- Alimta® (pemetrexed disodium)
- Alymsys® (bevacizumab) (except for ophthalmological conditions)
- Avastin®‡ (bevacizumab) (except for ophthalmological conditions)
- Blincyto® (blinatumomab)
- Cyramza® (ramucirumab)
- Darzalex® (daratumumab)
- Darzalex Faspro™ (daratumumab/hyaluronidase-fihj)
- Elahere® (mirvetuximab soravtansine-gynx)
- Enhertu (fam-trastuzumab-deruxtecan-nxki)
- epcoritamab*
- Erbitux® (cetuximab)
- Erwinaze® (asparaginase *Erwinia chrysanthemi*)
- glofitamab*
- Herceptin®‡ (trastuzumab)
- Herceptin Hylecta™ Trastuzumab
- Herzuma ® (trastuzumab-pkrb)
- Imjudo® (tremelimumab)
- Kadcyla® (ado-trastuzumab emtansinel)
- Kanjinti™ (trastuzumab-anns)
- Kimmtrak®(tebentafusp-tebn)
- Kyprolis® (carfilzomib)
- Lumoxiti™ (moxetumomab pasudotox-tdfk)
- Lunsumio™ (mosumetuzumab-axgb)
- Margenza™ (margetuximab)
- mirvetuximab soravtansine*
- Monjuvi® (tafasitamab-cxix)
- mosunetuzumab*
- Mvasi™ (bevacizumab- awwb) (except for ophthalmological conditions)
- Ogivri™ (trastuzumab-dkst)
- Ontruzant® (trastuzumab-dttb)
- Opdualag™ (nivolumab and relatlimab-rmbw)
- oportuzumab monatox*
- Padcev™ (enfortumab vedotin-ejfv)
- Pemfexy™ (pemetrexed)
- Perjeta® (pertuzumab)
- Phesgo™ (pertuzumab/trastuzumab/hyaluronidase-zzxf)
- Polivy™ Polatuzumab vedotin-piiq
- Poteligeo™ (mogamulizumab)
- Provenge® (sipuleucel-T)
- Riabni™ (rituximab-arrx)
- Rituxan®‡ (rituximab)
- Rituxan Hycela™ (rituximab/hyaluronidase human)
- Ruxience™ Rituximab-pvvr
- Rybrevant (amivantamab-vmjw)
- Rylaze™ (asparaginase *Erwinia chrysanthemi* [recombinant]-rywn)
- Sarclisa® (isatuximab-irfc)
- SH-111*
- Taclanits* (paclitaxel injection concentrate for suspension)
- teclistamab*
- Tecvayli™ (teclistamab)
- Tivdak™ (tisotumab vedotin-tftv)
- Trazimera™ (trastuzumab-qyyp)
- tremelimumab*
- Trodelvy™ (sacituzumab govitecan-hziy)
- Truxima® (rituximab-abbs)
- Vegzelma® (bevacizumab-adcd) (excect for ophthalmological conditions)
- Yervoy™ (ipilimumab)
- Zepzelca™ (lurbinectedin)
- Zirabev® (except for ophthalmological conditions)
- Zynlonta™ (loncastuximab tesirine)

Anti-PD-1/ PD-L1 human monoclonal antibodies/Chemotherapy**

- balstilimab*
- Bavencio® (avelumab)
- Imfinzi™ (durvalumab)
- Jemperli (dostarlimab-gxly)
- Keytruda™ (pembrolizumab)
- Libtayo® (cemiplimab-rwlc)
- Opdivo® (nivolumab)
- penpulimab*
- retifanlimab*
- sintilimab*
- Tecentriq™ (atezolizumab)
- tislelizumab*
- toripalimab*

Bone-modifying agents

- Evenity® (romosozumab-aqqg)
- Prolia® (denosumab)
- Xgeva® (denosumab)

Botulinum toxin agents

- Botox® (onabotulinumtoxinA)

Chemotherapy-induced nausea and vomiting (CINV) agents

- Sustol® (granisetron extended-release for injection)

Chimeric antigen receptor (CAR-T) therapies/Chemotherapy**

- Abecma™ (idecabtagene vicleucel)
- Breyanzi® (lisocabtagene maraleucel)
- Carvykti™ (ciltacabtagene autoleucel)
- Kymriah™ (tisagenlecleucel)
- Tecartus™ (brexucabtagene autoleucel)
- Yescarta™ (axicabtagene ciloleucel)

Endocrine/metabolic agents

- Acthar H.P. ® (corticotropin)
- cosyntropin depot*
- Makena® (hydroxyprogesterone caproate)
- Sandostatin® LAR (octreotide) **/chemotherapy**
- Somatuline® depot (lanreotide) **/chemotherapy**

Enzyme replacement agents**

- Aldurazyme® (laronidase)
- Brineura™ (cerliponase alfa)
- Cerezyme® (imiglucerase)
- cipaglucosidase alfa*
- Elaprase® (idursulfase)
- Elelyso® (taliglucerase alfa)
- Fabrazyme® (agalsidase beta)
- Kanuma® (sebelipase alfa)
- Lamzede® (velmanase alfa-tycv)
- Lumizyme® (alglucosidase alfa)
- Mepsevii™ (vestronidase alfa-vjbk)
- Naglazyme® (galsulfase)
- Nexviazyme® (avalglucosidase alfa)
- pegunigalsidase alfa*
- Revcovi™ (elapegademase-lvlr)
- Vimizim™ (elosulfase alfa)
- VPRIV® (velaglucerase alfa)
- Xenpozyme® (olipudase alfa)

Gene Replacement/Gene Editing therapy**

- beremagene

‡ Precertification requirements apply to all FDA-approved biosimilars to this reference product.

* Pending FDA approval.

** All drugs that can be classified under this header require precertification. This includes any unlisted brand or generic names or biosimilars, as well as new drugs that are approved by the FDA in that class during the course of the benefit year.

Specialty drugs that require precertification

(continued)

All listed brands and their generic equivalents or biosimilars require precertification. This list is subject to change.

- geperpavec*
- etranacogene dezaparvovec*
- Luxturna™ (voretigene neparvovec-rzyl)
- Roctavian* (valoctocogene roxaparvovec)
- Skysona™ (elivaldogene autotemcel)
- Zolgensma® (onasemnogene abeparvovec-xioi)
- Zynteglo® (betibeglogene autotemcel)

Hemophilia/Coagulation factors**

Hyaluronate acid products

- Durolane®
- Euflexxa™
- Gel-One®
- Gelsyn-3™
- GenVisc 850®
- Hyalgan®
- Hymovis®
- Supartz®
- Synojoynt™
- Triluron™
- TriVisc™
- VISCO-3®

Immunological agents

- Actemra® IV (tocilizumab)
- Avsola™ (infliximab-axxq)
- Benlysta® IV (belimumab)
- Entyvio™ (vedolizumab)
- Ilumya™ (infliximab-dyyb)
- Inflectra™ (tildrakizumab- asmn)
- Infliximab (unbranded)
- Ixifi™ (infliximab-qbtx)
- mirikizumab*
- Orencia® IV (abatacept)
- Remicade®‡ (infliximab)
- Renflexis™ (infliximab- abda)
- Saphnelo™(anifrolumab)
- Simponi® Aria (golimumab for infusion)
- Skyrizi ® IV*(risankizumab-rzaa)
- Spevigo® (spesolimab)
- Stelara® IV (ustekinumab)

Intravenous Immune Globulin/ Subcutaneous Immune Globulin (IVIG/SCIG)**

Multiple sclerosis agents**

- Lemtrada® (alemtuzumab)
- Ocrevus™ (ocrelizumab)
- Tysabri® (natalizumab)
- ublituximab*

Neutropenia

- efbemalenograstim*
- Fulphila™ (pegfilgrastim- jmbd)
- Fylnetra® (pegfilgrastim-pbbk)
- Lapelga*
- Neulasta®‡ (pegfilgrastim)
- Neulasta Onpro™ (pegfilgrastim body injector kit)
- Neupogen® (filgrastim)
- Nivestym™ (filgrastim-aafi)
- Nyvepria™ (pegfilgrastim-apgf)
- plinabulin*
- Releuko ™ (filgrastim-ayow)
- Rolvedon™ (eflapegrastim)
- Stimufend® (pegfilgrastim-fpgk)
- Udenyca ™ (pegfilgrastim-cbqv)
- Ziextenzo® (pegfilgrastim-bmez)

Ophthalmic agents

- abicipar*
- aflibercept (high-dose)*
- Beovu® (brolucizumab-dbll)
- bevacizumab-vikg*
- Byooviz™ (ranibizumab-nuna)
- Cimerli™ (ranibizumab-eqrn)
- Eylea®‡ (aflibercept)
- Lucentis®‡ (ranibizumab)
- Susvimo™ (ranibizumab injection, port delivery system)
- Tepezza™ (teprotumumab-trbw)
- Vabysmo® (faricimab-svoa)

Pulmonary arterial hypertension**

- Flolan® (epoprostenol GM)
- Remodulin® (treprostinil)
- Revatio® (sildenafil)
- Trevyent* (treprostinil)
- Tyvaso® (treprostinil)
- Veletri® (epoprostenol AS)
- Ventavis® (iloprost)

Respiratory agents

- Cinqair® (reslizumab)
- Synagis® (respiratory syncytial virus [RSV], monoclonal antibody, recombinant)
- Tezspire™ (tezepelumab-ekko)
- Xolair® (omalizumab)

Respiratory enzymes (Alpha-1 antitrypsin)**

- Aralast
- Glassia™
- Prolastin®
- Zemaira®

Miscellaneous therapeutic agents

- Adakveo® (crizanlizumab-tmca)
- Amvuttra™ (vutrisiran)
- Cosela® (trilaciclib)
- Crysvita® (burosumab-twza)
- donislecel*
- Enjaymo (sutimlimab-jome)
- Evkeeza™ (evinacumab)
- Gamifant® (emapalumab-lzsg)
- Givlaari® (givosiran)
- Ilaris® (canakinumab)
- Krystexxa® (pegloticase)
- Leqvio® (inclisiran)
- narsoplimab*
- Onpattro ™ (patisiran)
- Oxlumo ® (lumasiran)
- Reblozyl® (luspatercept-aamt)
- Remune*
- Rethymic™ (allogeneic processed thymus tissue-agdc)
- Soliris®‡ (eculizumab)
- Spinraza™ (nusinersen)
- teplizumab*
- Tzield™ (teplizumab)
- Ultomiris ™ (ravulizumab-cwvz)
- Uplizna™ (inebilizumab)
- Vyepti™ (eptinezumab-jjmr)
- Vyvgart™ (efgartigimod alfa-fcab)
- Xiaflex®

‡ Precertification requirements apply to all FDA-approved biosimilars to this reference product.

* Pending FDA approval.

** All drugs that can be classified under this header require precertification. This includes any unlisted brand or generic names or biosimilars, as well as new drugs that are approved by the FDA in that class during the course of the benefit year.

Ohio Carpenters' Fringe Benefit Funds
Health Fund: P.O. Box 1257, Troy, MI 48099
Pension and Annuity Funds: P.O. Box 31580, Independence, OH 44131
Phone: (248) 641-4967 Toll Free: (855) 837-3528 Fax: (216) 539-3221
Website: www.ocbenefits.org

January 2024

To: Participants of the Ohio Carpenters Health Fund

From: Board of Trustees of the Ohio Carpenters Health Fund

Please read this Notice carefully. It contains important information about changes to the Ohio Carpenters' Health Plan (Plan). Please keep this notice with your Ohio Carpenters' Health Plan Summary Plan Description (SPD).

WEIGHT LOSS DRUGS

You previously received a notice dated November 2023 regarding certain plan changes. To clarify, these changes are not applicable to Medicare eligible Participants.

In particular, the November 2023 notice indicated that the Plan covers weight loss drugs, Glucagon-like peptide-1 (GLP-1s), under certain circumstances for Active and Pre-Medicare Participants through the Fund's Prescription Drug Program.

However, Medicare eligible Participants and Dependents have prescription drug coverage through an Employer Group Waiver Plan (EGWP), which coordinates prescription drug coverage with Medicare Parts C and D. Currently, Medicare only covers GLP-1s for those diagnosed with diabetes, but not for obesity or weight loss. Therefore, the EGWP excludes coverage for GLP-1s prescribed for weight loss.

GENE THERAPY EXLCUSION

Currently, the Plan excludes coverage for gene therapy.

Effective January 1, 2024, the Plan will exclude coverage for "[a]ll FDA-approved Cellular and Gene Therapy."

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE FUND OFFICE AT (855)-837-3528.

W2700694

Ohio Carpenters' Fringe Benefit Funds
Health Fund: P.O. Box 1257, Troy, MI 48099
Pension and Annuity Funds: P.O. Box 31580, Independence, OH 44131
Phone: (248) 641-4967 Toll Free: (855) 837-3528 Fax: (216) 539-3221
Website: www.ocbenefits.org

April 2024

To: All Participants of the Ohio Carpenters Health Plan

From: Board of Trustees of the Ohio Carpenters Health Plan

Please read this Notice carefully. It contains important information about changes to the Ohio Carpenters Health Plan (Plan). Please keep this notice with your Ohio Carpenters Health Fund Summary Plan Description (SPD).

PLAN CHANGES

1. INCREASE IN MONTHLY PREMIUM AND BANKING THRESHOLD EFFECTIVE JULY 1, 2024

The following adjustments to the current rates for Participants will be effective July 1, 2024:

MONTHLY RATES FOR ACTIVES AND RETIREES	CURRENT	NEW
Active Bargained Premium* (Single or Family)	$950	$1,150
Active Bargained (Single or Family) Banking Threshold**	$1,150	$1,300
Shop Plan Premium (Single)	$450	$500
Shop Plan (Single) Banking Threshold	$550	$600
Shop Plan Premium (Family)	$750	$850
Shop Plan (Family) Banking Threshold	$600	$950
Active Non-Bargained Premium (Single or Family)	$1,050	$1,250
Non-Medicare Retiree (Single or Family)	$950	$1,150
One Medicare and at least one Non-Medicare (Family)	$950	$1,150
Medicare Supplement Only, No Rx (Single)	$246	$246
Medicare Supplement Only, No Rx (Family)	$432	$432
Medicare Advantage + EGWP (Single)	$296	$296
Medicare Advantage + EGWP (Family)	$532	$532

*Previously referred to as the monthly Cost of Coverage.
**Monthly contributions received above the Banking Threshold are credited to a Participant's Dollar Bank.

2. FUTURE INCREASES IN PREMIUM AND BANKING THRESHOLD FOR SHOP PLAN ONLY

The Premium and Banking Threshold for Shop Employees who elect the Full Plan are the same as the rates set forth for Active Bargained Employees set forth in Item 1, above. The following are increases in the Premiums and Thresholds for those who elect the Shop Plan are effective July 1, 2024, and July 1, 2025:

	CURRENT	EFFECTIVE 7/1/24	EFFECTIVE 7/1/25
Shop Plan Premium (Single)	$450	$500	$550
Shop Plan (Single) Banking Threshold	$550	$600	$650
Shop Plan Premium (Family)	$750	$850	$900
Shop Plan (Family) Banking Threshold	$850	$950	$1000

3. HEARING AID BENEFIT EFFECTIVE MAY 1, 2024

Currently, the Plan provides self-insured hearing aid benefits without any specific network as follows:

(a) Audiometric Examinations, Hearing Aid Evaluation Tests, Hearing Aids, and Hearing Aid Conformity Evaluations, once every four years for each ear and not to exceed a total of $3,000.00 every four years per Covered Person; and

(b) up to $250.00 annually to repair a Hearing Aid that is out of warranty.

Effective May 1, 2024, the Trustees are pleased to announce that above benefits will be provided through TruHearing, and that the $3,000 benefit described above will be provided every three years, instead of four years.

A list of TruHearing Providers is available at www.truhearing.com. Coverage will only be provided through a TruHearing Provider. Hearing aids and services will not be covered if obtained from out-of-network providers. You are encouraged to use a TruHearing Provider to decrease your costs!

4. RETIREES RETURNING TO WORK

As a reminder, if a Retiree returns to work, he must notify the Fund Office. The Retiree will continue to make Retiree self-payments for coverage and Contributions received on behalf of a Retiree will be credited to his/her MRA, less the cost of the Differential (unless the Retiree returns to work in a shop, in which case effective 2/1/23 the Differential is not deducted). Notwithstanding, if a Retiree ceases drawing a pension benefit and informs the Fund Office that he/she desires to re-establish eligibility as an Active Employee, such Contributions will be credited per Section 2.1 of the Plan.

5. ADMINISTRATIVE FEE - INITIAL ELIGIBILITY

As a reminder, prior to establishing initial eligibility under the provisions of the Plan, an administration fee of $25.00 will be deducted from Contributions received and the balance of the Contributions will be credited to the Employee's Dollar Bank for each month the Participant remains ineligible.

6. USE OF BANK FOR MEDICAL REIMBURSEMENT ACCOUNT (MRA)

As a reminder, when the balance in Active Participant's Bank exceeds three times the Premium, such excess may be used for unreimbursed medical expenses.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE FUND OFFICE AT (855) 837-3528

Dear member,

At Ohio Carpenters' Health Plan, we're always looking to help improve your health and well-being. That's why we're pleased to let you know about TruHearing®, our new exclusive vendor and a leading provider of hearing health benefits that will allow you to purchase hearing aids at little to no out-of-pocket cost to you.

Effective May 1, 2024, you'll have access to hearing health services including a comprehensive hearing exam ($0 copay), plus the latest hearing aid models, styles, and technologies through TruHearing. Your benefit allowance provides $3,000 total every 3 years.

In addition to high-quality hearing aids featuring top-of-the-line technology from the six leading manufacturers, this program also includes the following:

- 60-day, risk-free trial
- 1 year of follow-up visits
- 80 free batteries per non-rechargeable hearing aid
- 3-year manufacturer warranty

Here's how to get started if you're interested in learning more or scheduling an appointment.

1. Call TruHearing at **1-877-653-8876**
2. A Hearing Consultant will answer your questions and schedule an appointment with a TruHearing provider near you
3. TruHearing will ensure you're taken care of at every step of the way

Because this is a special, exclusive offer for Ohio Carpenters' Health Plan Fund members, all appointments must be made through TruHearing. Please see the enclosed flyer for more details.

We hope you will be able to take advantage of this additional benefit to improve your hearing and overall health.

Sincerely,

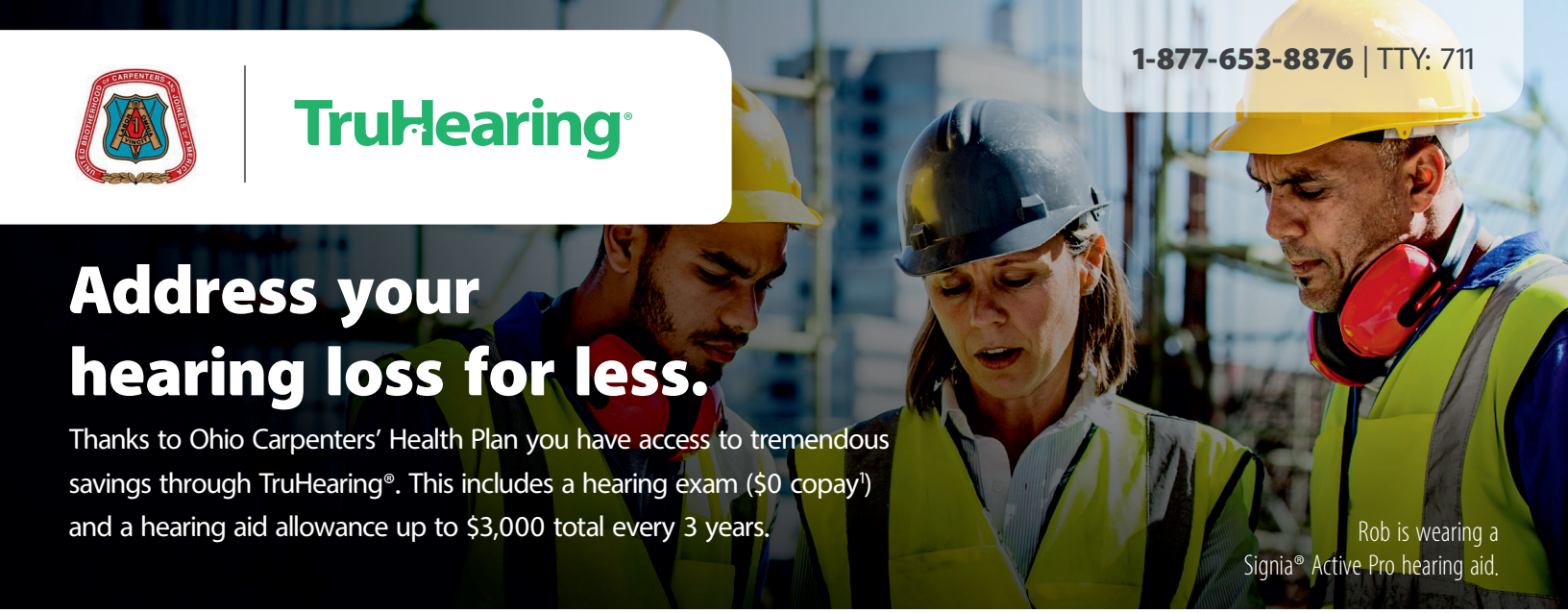
Ohio Carpenters' Health Plan
Board of Trustees

TruHearing®

1-877-653-8876 | TTY: 711

Address your hearing loss for less.

Thanks to Ohio Carpenters' Health Plan you have access to tremendous savings through TruHearing®. This includes a hearing exam ($0 copay[1]) and a hearing aid allowance up to $3,000 total every 3 years.



Rob is wearing a Signia® Active Pro hearing aid.

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**

Your hearing aid purchase includes

- Risk-free **60-day** trial period
- **1 year** of follow-up visits
- **80 free batteries** per non-rechargeable hearing aid
- Full **3-year manufacturer** warranty

Call TruHearing to get started.

1-877-653-8876 | TTY: 711

Hours: 8am–8pm, Monday–Friday

TruHearing®

1-877-653-8876 | TTY: 711

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[2]

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

Sarah is wearing TruHearing Advanced RIC hearing aids.

The best tech for less.

Enhanced speech clarity
to understand voices above background noise

Bluetooth® streaming
from your phone for convenient calls, music, movies, and more

Potential tinnitus relief
since treating your hearing loss may be an effective tinnitus treatment

Give us a call.
Your dedicated Hearing Consultant will answer any questions you might have, check your coverage with the fund, and schedule an appointment with a TruHearing provider near you. (Teleaudiology options may also be available.)

Go to your appointment.
Your local hearing health provider will perform a hearing exam and, if needed, recommend hearing aids that best fit your hearing loss, budget, and lifestyle.

Get the support you need.
Follow-up care from your provider ensures your hearing aids feel right and perform properly, and ongoing support from TruHearing will help you get comfortable with your new hearing aids.

Schedule an appointment
1-877-653-8876 | TTY: 711
Hours: 8am–8pm, Monday–Friday

Learn more
TruHearing.com/OhioCarpenters

These hearing benefits are subject to change at the fund's discretion.

[1] Must be performed by a TruHearing provider.

[2] MarkeTrak 2022.

 Hearing aid pricing based on a February 2024 survey of national average hearing aid prices. Follow-up provider visits included for one year following hearing aid purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing Hearing Consultant. 516221-2_0424

Ohio Carpenters' Fringe Benefit Funds
Health Fund: P.O. Box 1257, Troy, MI 48099
Pension and Annuity Funds: P.O. Box 31580, Independence, OH 44131
Phone: (248) 641-4967 Toll Free: (855) 837-3528 Fax: (216) 539-3221
Website: www.ocbenefits.org

June 2024

To: All Participants of the Ohio Carpenters Health Plan

From: Board of Trustees of the Ohio Carpenters Health Plan

Please read this Notice carefully. It contains important information about changes to the Ohio Carpenters Health Plan (Plan). Please keep this notice with your Ohio Carpenters Health Fund Summary Plan Description (SPD).

You previously received a notice regarding changes to the Plan's Hearing Aid Benefit Effective May 1, 2024 (set forth below). We are resending this notice to emphasize that the Hearing Aid Benefit is applicable to Actives, Non-Medicare Retirees, and Non-Medicare Dependents, only.

Please note that Medicare Retirees enrolled in the fully insured Medicare Policy through Humana have other hearing coverage through Humana.

HEARING AID BENEFIT EFFECTIVE MAY 1, 2024 FOR ACTIVES, NON-MEDICARE RETIREES, AND NON-MEDICARE DEPENDENTS

Currently, the Plan provides self-insured hearing aid benefits without any specific network as follows:

(a) Audiometric Examinations, Hearing Aid Evaluation Tests, Hearing Aids, and Hearing Aid Conformity Evaluations, once every four years for each ear and not to exceed a total of $3,000.00 every four years per Covered Person; and

(b) up to $250.00 annually to repair a Hearing Aid that is out of warranty.

Effective May 1, 2024, the Trustees are pleased to announce that above benefits will be provided through TruHearing, and that the $3,000 benefit described above to be provided every three years, instead of four years.

A list of TruHearing Providers is available at www.truhearing.com. Coverage will only be provided through a TruHearing Provider. Hearing aids and services will not be covered if obtained from out-of-network providers. You are encouraged to use a TruHearing Provider to save your money!

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE FUND OFFICE AT (855) 837-3528

W2733732

Ohio Carpenters' Fringe Benefit Funds
Health Fund: P.O. Box 1257, Troy, MI 48099
Pension and Annuity Funds: P.O. Box 31580, Independence, OH 44131
Phone: (248) 641-4967 Toll Free: (855) 837-3528 Fax: (216) 539-3221
Website: www.ocbenefits.org

To: All Participants of the Ohio Carpenters Health Plan

From: Board of Trustees of the Ohio Carpenters Health Plan

Please read this notice carefully. It contains important information about changes to the Ohio Carpenters Health Plan (Plan). Please keep this notice with your Ohio Carpenters Health Fund Summary Plan Description (SPD).

GLP-1 MEDICATIONS FOR WEIGHT LOSS FOR ACTIVES AND PRE-MEDICARE PARTICIPANTS

Some of you may have received a notice regarding changes to coverage for weight loss drugs taking effect July 1, 2024. On further review, no changes will be made regarding coverage for weight loss drugs until October 1, 2024. Those changes are set forth below.

What are the minimum qualifications for coverage?

Effective October 1, 2024, to be able to obtain coverage for a weight loss drug or GLP-1 medication for weight loss, at a minimum, a covered person must meet all the following requirements at the time the drug is started:

(a) Be at least 18 years of age.
(b) Have a body mass index (BMI):
  (i) Equal or greater than 32; or
  (ii) Equal or greater than 27 and have at least two of the following risk factors:
    (A) Type 2 diabetes
    (B) Hypertension
    (C) Dyslipidemia
    (D) Obstructive sleep apnea
    (E) Cardiovascular or coronary artery disease
    (F) Knee osteoarthritis
    (G) Asthma
    (H) Chronic obstructive pulmonary disease
    (I) Non-alcoholic fatty liver disease
    (J) Polycystic ovarian syndrome
(c) Submit evidence that the covered person will or has been engaged in behavioral modification and a reduced-calorie diet

IMPORTANT NOTE FOR THOSE ALREADY RECEIVING COVERAGE FOR WEIGHT LOSS DRUGS: As of October 1, 2024, if you would not have qualified for coverage under the new criteria when you began taking the drug, you will no longer be approved for coverage. Here are two examples of how this will work:

Example 1: On June 1, 2024, Participant A had a BMI of 31 and was approved for weight loss drug coverage. As of October 1, assuming Participant A's BMI is under 32, Participant A will not be eligible for continued coverage unless Participant A otherwise meets the new criteria.

Example 2: On June 1, 2024, Participant B had a BMI of 33 (baseline BMI) and was approved for weight loss drug coverage. As of October 1, Participant B has a BMI of 31 and, assuming all other coverage requirements are met, will be eligible for continued coverage because Participant B's baseline BMI meets the new criteria.

What other criteria must be met to obtain coverage for weight loss drugs?

Coverage is also subject to the following conditions:

(a) Prior authorization is required for coverage to begin and then at least once per year in subsequent years. For each prior authorization after initial approval, have or maintain a 5% weight loss from initial weight.

(b) Enrollment and engagement with Omada, a virtual health program, provided by Express Scripts, the pharmacy benefits manager (PBM). Omada helps members create healthier habits to achieve long-lasting results. To continue coverage of a weight loss medication, you must meet the following requirements each month:

(1) Use the Omada app four times a month, by doing lessons or engaging with your health coach, peer group or online community.

(2) Weigh in four times a month using the smart scale provided by Omada.

To enroll in Omada, register or log in to esrx.com/healthsolutions on or after October 1, 2024, to get your Access Code. Then sign up at omadahealth.com/esi or download the Omada mobile app. Please see the enclosed brochure.

If you want your weight loss GLP-1 medication to be covered by your plan, ask your doctor to visit the Express Scripts online portal at esrx.com/PA or call Express Scripts at 800.417.1764 to arrange for a review **on or after October 1, 2024. If your doctor doesn't visit esrx.com/PA or call and get approval, you'll be responsible for the full cost.**

A list of covered weight loss drugs and the applicable drug eligibility criteria are available at the Fund Office or by contacting Express Scripts, the PBM at 800.716.2932. The list of covered drugs and eligibility criteria may change from time to time.

GLP-1 MEDICATIONS FOR DIABETES FOR ACTIVES AND PRE-MEDICARE PARTICIPANTS

If you are diabetic and have been prescribed a GLP-1, the above requirements do not apply to you to begin or to continue receiving this drug provided Express Scripts has confirmation of your diabetes diagnosis. If they do not have this, Express Scripts will reach out to your treating provider for this information.

W2741148/OHIO/129012

Central Midwest Regional Council of Carpenters'
Welfare Fund

P.O. Box 1257, Troy, MI 48099
Phone: (800) 700-6756 - (855)837- 3528

SUMMARY OF MATERIAL MODIFICATIONS: PLEASE READ CAREFULLY AND SAVE FOR FUTURE REFERENCE.

To: All Participants of the Ohio Carpenters Health Fund (Ohio Fund) and Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund (IKORCC Fund)

From: Boards of Trustees of the Ohio and IKORCC Funds

Date: November 1, 2024

TAKING ADVANTAGE OF OUR STRENGTH IN NUMBERS!

With constantly increasing health care costs, to take advantage of our strength in numbers and save administrative costs, enhance negotiating ability, and continue to provide stable and comprehensive benefits, the Boards of Trustees of the Ohio and IKORCC Funds are pleased to announce that effective January 1, 2025, the IKORCC Fund will merge into the Ohio Fund. To reflect our unity, the Ohio Fund has been renamed the Central Midwest Regional Council of Carpenters Welfare Fund (CMRCC Fund).

A number of changes, and enhancements, are taking place – for example, for Actives and Non-Medicare participants, there is an increase in in-network coverage on many services to 80%, (preventive services required by law remain covered by law at 100%), and Medicare Retirees have an increased hearing benefit of $3,000 every three years.

Attached as Exhibit A is a summary of changes effective January 1, 2025. Please take time to read carefully. Soon, you will be receiving a more detailed explanation of benefits and eligibility requirements in a new Summary Plan Description for the CMRCC Fund.

The following are not changing:

- Your Medical Network Provider - Independence
- Your Prescription Benefit Manager - ESI
- Your Medicare Advantage Plan Provider - Humana
- Your Dental Network - Delta Dental
- Active/Pre-Medicare Participants' Hearing Benefit Provider - TruHearing. TruHearing will also become the provider for Medicare Participants also (as explained in Exhibit A).
- **Your ID Cards. You will not be receiving new ID cards at this time. You may receive new ID cards in the future, but for now all Participants should keep their existing ID cards until further notice.**

If you have any questions, please contact the Fund Office at (800) 700-6756

W2766181

EXHIBIT A
PLAN PROVISIONS EFFECTIVE JANUARY 1, 2025

Table of Contents

PLEASE BE ADVISED THAT EXHIBIT A IS A SUMMARY OF BENEFITS. ALL STATEMENTS IN THIS NOTICE ARE SUBJECT TO ALL PLAN PROVISIONS, EXCLUSIONS, AND LIMITATIONS. IN THE EVENT OF ANY INCONSISTENCY BETWEEN THE TERMS OF THE PLAN AND THIS NOTICE, THE TERMS OF THE PLAN CONTROL.

1. Chart of Medical Benefits: Actives/Pre-Medicare Covered Persons (Except Shop Employees, Whose Benefits Are Not Changing)

Preventive services as required by law are covered at 100%. Please note the increase in in-network coverage on most other services to 80%!

All benefits are subject to Plan exclusions and limitations.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Deductible		
Individual	$500	$500
Family	$1,000	$1,250
Maximum Out of Pocket (Medical Benefits Only)[1]		
Individual	$3,500	$5,000
Family	$7,000	$10,000
Office Visits/Urgent Care/On-Line All services received during on visit billed separately, and accordingly have separate cost sharing requirements.		
Primary Care Physician	100% after $20 copay.	60% of Applicable Medicare Rate after deductible.
Specialist and Consultations	100% after $40 copay.	60% of Applicable Medicare Rate after deductible.
Pre- and Post- Natal Care that is not Preventive Care	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Allergy Testing/Injections -Prescription drugs and biologicals that cannot be self-administered and are furnished as part of Physician's professional service, such an antibiotics and joint injections.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Diagnostic Lab/X-Ray	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Surgery	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Urgent Care	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Telehealth: Teladoc	100%.	No coverage.
Preventive Services Required to be Covered by Law Items and services covered by the Plan for preventive services will be updated and amended automatically as required by law, which may include additions to and subtractions from the representative list of covered items set forth below.		
For Adults: • Screenings, most commonly covered annually, including for the following: o Abdominal Aortic Aneurysm o Cholesterol o Colorectal Cancer (and follow-up, if required by law) o Depression o Hepatitis C o HIV	100%.	60% of Applicable Medicare Rate after deductible.

[1] Only deductibles, coinsurance, and copays are attributable to the out-of-pocket maximum accumulators.

○ Hypertension ○ Latent Tuberculosis ○ Lung Cancer ○ Prediabetes and Type 2 Diabetes ○ Syphilis ○ Unhealthy Alcohol and Drug Use • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages, and populations may vary. • Behavioral Interventions (including, when required by law, nutritional counseling) for: ○ Skin Cancer Prevention; ○ Tobacco Smoking Cessation; ○ Weight Loss to Prevent Obesity-Related Morbidity and Mortality; ○ Healthy Diet and Physical Activity for Cardiovascular Disease Prevention; ○ Unhealthy Alcohol Use		
For Women: • Screenings, including for the following: ○ Anxiety ○ Breast Cancer (Mammography) ○ Cervical Cancer ○ Diabetes After Gestational Diabetes ○ Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults ○ Osteoporosis ○ Urinary Incontinence ○ STIs (including Chlamydia, Gonorrhea • BRCA-Related Cancer Risk Assessment, Genetic Counseling and Genetic Testing • Obesity Prevention Counseling • Sexually Transmitted Infections Counseling • Well-Women Visits [which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits]	100%.	60% of Applicable Medicare Rate after deductible.
For Pregnant Women or Women Who May Become Pregnant: • Screenings, including for the following: ○ Anxiety ○ Bacteriuria ○ Contraception ○ Gestational Diabetes ○ Rh(D) Incompatibility	100%	60% of Applicable Medicare Rate after deductible.

○ STIs (including Chlamydia, Gonorrhea, Hepatitis B, HIV, and Syphilis) ○ Preeclampsia ○ Urinary Tract or other Infection • Breastfeeding Services and Supplies (including, but not limited to double electric breast pumps [including pump parts and maintenance] and breast milk storage supplies • Contraception Education, Counseling, Provision of Contraceptives, and Follow-up Care [including sterilization surgery] • Healthy Weight and Weight Gain Behavioral Counseling • Perinatal Depression Preventive Interventions • Preeclampsia Prevention • Substance Use Assessment		
For Children/ Adolescents/ Young Adults **[Newborn—21 years old]:** • Screenings, including for the following: ○ Anemia ○ Autism Spectrum Disorder (coverage is limited to screening and diagnosis only) ○ Behavioral/Social/Emotional ○ Blood Pressure ○ Cervical Dysplasia ○ Depression and Suicide Risk ○ Developmental ○ Dyslipidemia ○ Hearing ○ Lead Level ○ Newborn Blood, Bilirubin, and Critical Congenital Heart Disease ○ Obesity ○ Scoliosis ○ STIs (including but not limited to Chlamydia, Gonorrhea, HIV, Syphilis) ○ Tobacco, Alcohol, and Drug Use ○ Tuberculosis ○ Vision • Fluoride Varnish and Oral Fluoride Supplementation • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Doses, recommended ages, and populations may vary.	100%	60% of Applicable Medicare Rate after deductible.

• Oral Health Risk Assessment and Referral • Sudden Cardiac Arrest/Death Risk Assessment • Tobacco, Alcohol, and Drug Use Interventions • Well Baby/Child Examinations • Behavioral Interventions (including, when required by law, nutritional counseling) for: o Skin Cancer Prevention; o Weight Loss to Improve Obesity-Related Weight Status		
Preventive Services Not Required To Be Covered By Law		
Prostate tests and immunizations, including doctor visit [one per year]	100%	60% of Applicable Medicare Rate after deductible.
Annual Physicals [one per year]	100%	60% of Applicable Medicare Rate after deductible.
Inpatient Hospital **Precertification Required.**		
Facility – Inpatient Hospital (Semi-private room; private room only when Medically Necessary)	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Physician/Surgeon	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Birthing Center/Ambulatory Surgery Center	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Surgery -Two or more surgeries through same opening during on operation: coverage only for most complex procedure (but if such surgeries are mutually exclusive, coverage will be provided for each). - Two or more surgical procedures performed through different openings during one operation: coverage provided for the most complex procedure for the amount payable by the Plan as if it was the sole procedure, and coverage provided for the secondary procedures for half the amount payable by the Plan as if each was the sole procedure. -Multiple foot surgeries on same foot during one operation: coverage provided for the most complex procedure up to the amount payable by the Plan as if it were the sole procedure, coverage provided for the two next most complex procedures for half the amount payable by the Plan as if each was the sole procedure, and for additional procedures coverage one-fourth the amount payable by the Plan if each were the sole procedure. -Includes surgery for morbid obesity limited to one surgery per lifetime where the eligible Participant must have a BMI of at least 35, must have Physician documented unsuccessful, non-surgical weight loss attempts within the previous	80% after deductible.	60% of Applicable Medicare Rate after deductible.

six months and at least one of the following associated medical conditions: Severe Sleep Apnea, Pickwickian Syndrome, Congestive Heart Failure, Cardiomyopathy, Insulin Dependent Diabetes or Severe Musculoskeletal Dysfunction		
Anesthesia	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Certified Registered Nurse Anesthetist	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Assistant Surgeon	80% after deductible.	60% of Applicable Medicare Rate after deductible.
In-Hospital Consultations	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Diagnostic Labs and Services (radiology, ultrasound, nuclear medicine, lab, pathology, EKG, EEG, MRI, and other electronic diagnostic medical procedures	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Labs	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Respiratory Therapy	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Maternity Care/Birthing Center (including midwife) **Special Notice Regarding Maternity Benefits:** Group health plans and health insurance issuers generally may not, under federal law, restrict benefits or require authorization for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). Where an earlier discharge is not against medical advice, a home or office visit for education, physical and home assessment, feeding, and routine tests not completed due to early discharge is covered if conducted by a Physician or nurse within 72 hours of discharge.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Organ Transplant Benefit Precertification Required.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Outpatient Care		
Surgery -Will cover second opinion for necessity of surgery and third opinion only if first and second disagree.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Diagnostic Labs and Services (radiology, x-ray, ultrasound, nuclear medicine, lab, pathology,	80% after deductible.	60% of Applicable Medicare Rate after deductible.

EKG, EEG, MRI, and other electronic diagnostic medical procedures)		
Emergency Services for an Emergency Medical Condition	80% after $250 copay. $250 copay waived if the patient is admitted to the hospital or if the reason for the emergency room visit is due to an accidental injury or life threatening condition.	80% after $250 copay. $250 copay waived if the patient is admitted to the hospital or if the reason for the emergency room visit is due to an accidental injury or life threatening condition.
Occupational/Physical/Speech Therapy -for therapies to treat non-mental health disorders, treatment must be restorative: i.e., to restore or improve movement/function, skills, or speech impaired due to an acute episode of disease, injury or trauma, or a congenital anomaly that is expected to achieve measurable improvement within a reasonable time frame (usually four – six months) -for therapies to treat mental health or substance use disorders, treatment is not required to be restorative.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Applied Behavioral Analysis (ABA) Therapy to treat Autism Spectrum Disorder	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Respiratory Therapy	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Cardiac Rehabilitation	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Hemodialysis	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Acute Kidney Dialysis	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Second Surgical Opinion	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Hyperbaric Therapy – only if provided by a Hospital.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Mental Health/Substance Use Disorder		
Inpatient Hospital Care -Precertification Required. -Includes counseling for Covered Persons who are Family Members.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Inpatient Residential Treatment Facility -60-day limit per year -Precertification required.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Outpatient -must be administered by a medical doctor, psychiatrist, clinical psychologist, or licensed practitioner, including licensed social worker.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Other Providers		
Chiropractors -Limit 25 visits annually (office visits, manipulations, modalities, x-rays). Braces or	80% after deductible.	60% of Applicable Medicare Rate after deductible.

molds in conjunction with chiropractic care is not covered.		
Other Services		
Skilled Nursing Facility -Precertification Required -60-day visit limitation per year	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Home Health Care -limit 40 visits per year.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Private Duty Nursing -90 visits per plan year	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Home Infusion Therapy	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Hospice Care -must be provided at freestanding hospice facility or a hospice program sponsored by a Hospital or Home Health Care Agency. -Hospice services may be received in a private residence.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Durable Medical Equipment -includes rental fees not to exceed purchase price. -Expenses for special fittings, adaptions, maintenance, or repairs of such equipment are not considered covered charges. -DME having certain convenience or luxury features which are not medically necessary are not covered, except that benefits for the cost of standard equipment will be provided toward the cost of deluxe items.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Prosthetics - purchase, fitting, adjustments, repairs and replacements of prosthetic devices, including necessary supplies, that replace all or part of a missing body organ or limb and its adjoining tissues; or replace all or part of the function of a permanently useless or malfunctioning body organ or limb; this includes a cranial prosthesis medically necessary due to hair loss resulting from medical conditions such as alopecia areata or chemotherapy.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Medical Supplies -Must serve a specific therapeutic purpose such as needles, oxygen, syringes, and surgical dressings and other similar items and be provided per physician orders.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Ambulance -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	80% after deductible.	Ground: 60% of Applicable Medicare Rate after deductible. Air Ambulance: 80% of lesser of billed charges or the Qualified Payment Amount, after deductible (in-network deductible and in-network out-of-pocket maximums apply and out-of-network

		coinsurance and deductible for air ambulance counts towards in-network out of pocket maximums).
Abortion (therapeutic and elective – elective not subject to medical necessity requirement)	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Sterilization -Medical Necessity not required.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Sterilization reversal if medically necessary to treat a condition other than fertility	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Temporomandibular Joint Disorder -Maximum lifetime benefit per person $2,000	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Nutritional Counseling, as required to comply with the Mental Health Parity and Addiction Equity Act, as amended, and regulations promulgated thereunder.	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Coronavirus/COVID-19		
COVID-19 Testing as required by law	80% after deductible.	60% of Applicable Medicare Rate after deductible.
Treatment for COVID-19	80% after deductible.	60% of Applicable Medicare Rate after deductible.
OTC COVID-19 Testing – FDA approved tests (not for employment purposes)	80% coverage at retail and via direct-to-consumer shipping options provided by Pharmacy Benefits Manager	60% of Applicable Medicare Rate after deductible.

Out of network benefits processed as in-network: If the Fund Office confirms there is no suitable in-network provider within a 50-mile radius of the covered person's residence, then medical benefits will be processed as in network benefits.

Medical Services Outside of United States: Medical treatment and services rendered outside the United States will be covered only for Emergency medical conditions and will not include charges for travel or repatriation.

2. Prescription Drug Benefits: Actives, Non-Medicare Retirees, and Non-Medicare Dependents

Copayments for prescription drugs will be*:

Retail (up to 30 day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $40
Tier 3	Non-Preferred Brand: $80
Tier 4	Specialty: 25%, not to exceed $200
Notwithstanding above, if 4th or more fills of same Tier 1-3 drug at Retail, copayment increases to $100	
Mail Order (up to 90 day supply)	
Tier 1	Generic: $50
Tier 2	Preferred Brand: $100
Tier 3	Non-Preferred Brand: $200
Tier 4	Specialty: 25%, not to exceed $200

*Not all drugs are available in the supplies indicated on the above chart.

Brand Name Durg Obtained Where Generic Available: DAW-1 occurs when a prescriber writes a prescription directing the pharmacist to dispense the brand-name drug – in other words, no generic substitution. DAW-2 occurs when the covered person specifically requests the brand-name drug instead of the generic version. If a drug is dispensed DAW-2, meaning the covered person and not the prescriber requested the brand name drug, in addition to the above copayments, the covered person will also pay the price between the brand name drug and the generic substitute.

Out-of-Network: Participants who use an out of network pharmacy must pay the cost of the drug and submit original receipts to the Fund Office for reimbursement, which will not exceed the amount the Fund would have paid an in-network pharmacy,

Maximum Out of Pocket Costs: The 2025 maximum out of pocket costs for in-network prescription drugs is $5,700 single and $11,400 family. There is no out of pocket maximum for drugs obtained from out of network pharmacies.

ED Drugs: ED drugs will now be available to all Participants for 8 pills per every 30 days.

Covered Drugs: Subject to Plan exclusions, Federal Legend Drugs on the ESI formulary are covered.

3. Prescription Drug Benefits: Medicare Retirees and Medicare Dependents

Medicare Eligible Participants and Medicare Dependents will continue to have prescription drug benefits through the Employer Group Waiver Plan (EGWP) with ESI. The EGWP will use a 4-tier formulary there is no deductible applicable to this benefit, and co-payments are set forth below*:

Retail (up to 31-day supply)	
Tier 1	Generic: $10
Tier 2	Preferred Brand: $30
Tier 3	Non-Preferred Brand: $75
Tier 4	Specialty: $100
Retail (32-to-60-day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $60
Tier 3	Non-Preferred Brand: $150
Tier 4	Specialty: $200
Retail (up to 90-day supply)	
Tier 1	Generic: $30
Tier 2	Preferred Brand: $90
Tier 3	Non-Preferred Brand: $225
Tier 4	Specialty: $300
Mail Order (up to 90-day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $60
Tier 3	Non-Preferred Brand: $150
Tier 4	Specialty: $200

*Not all drugs are available in the supplies indicated on the above chart.

ED Drugs: ED drugs will now be available to all Participants. The CMRCC Fund will cover 8 pills per every 30 days.

4. Dental Benefits: Actives and Pre-Medicare Retirees and their Dependents. These benefits may also be elected by Medicare Retirees and their Dependents.

Dental benefits are provided to Actives, Pre-Medicare Retirees, and their Dependents. Effective January 1, 2025, they may also be elected by Medicare Retirees and their Dependents for an additional $25 monthly self-payment (which covers election of dental and vision benefits, below).

Annual maximum of $1,000 per Covered Person (not applicable to those under age 19) and a lifetime limit of $1,500 for orthodontics. There is no deductible for in-network services, but a $50 per Covered Person/$100 per Covered Family deductible for out-of-network services.

Covered Dental Services:

Diagnostic and Preventive Services – Covered 100%

(1) Examinations/evaluations (twice per calendar year).
(2) Teeth cleaning (twice per calendar year).
(3) Space maintainers (up to age 14).
(4) Sealants (first permanent molars to age 9; second permanent molars to age 14).
(5) Fluoride treatments (twice per calendar year up to age 19).
(6) Brush biopsy to detect oral cancer.
(7) Emergency palliative treatment to temporarily relieve pain.
(8) Radiographs: (Bitewing X-rays are payable once per calendar year. Full mouth x-rays (including bitewings) are payable once in any five-year period. A panographic x-ray (including bitewings) is considered a full mouth x-ray.

Basic Services – Covered 80%

(1) Oral surgery--extractions and dental surgery, including preoperative and postoperative care.
(2) Endodontic services--treatment of teeth with diseases or damaged nerves (for example, root canals).
(3) Periodontic services--treatment of diseases of the gums and supporting structures of the teeth.
(4) Relines and repairs-to bridges, partial dentures, and complete dentures.
(5) Minor Restorative Services-to rebuild and repair natural tooth structure damaged by disease or injury, including fillings and crown repair.

Major Services – Covered 50%

(1) Major Restorative Services-including crowns and onlays-- limited to once per tooth in any 5-year period.
(2) Prosthodontic Services-to replace missing natural teeth (such as bridges, endoseal implants, and partial and complete dentures) --limited to once per tooth in any 5-year period.

Orthodontic services to correct malposed teeth through age 18 – Covered 50%

5. Vision Benefits: Actives, Pre-Medicare Retirees, and their Dependents. These benefits may also be elected by Medicare Retirees and their Dependents.

Vision benefits are provided to Actives, Pre-Medicare Retirees, and their Dependents. Effective January 1, 2025, they may also be elected by Medicare Retirees and their Dependents for an additional $25 monthly self-payment (which covers election of dental, above, and vision benefits).

Vision Benefits	In-Network	Out-Of-Network
Eye Exam (once every 12 months)	100% after $10 Co-Payment	100% up to $45
Contacts (once every 12 months) Elective Medically Necessary	 100% after $60 copay up to $125 100%	 100% up to $105 100% up to $210
Frames (once every 24 months)	100% after $15 Co-payment up to $150 (retail) and $57 (wholesale) Featured Frames up to $170. Costco Frames up to $80.	100% up to $70
Lenses	100% (included in Frames Co-payment)	Single-Vision 100% up to $30 Bifocal Vision 100% up to $50 Trifocal Vision 100% up to $65 Lenticular Vision 100% up to $100
Safety Glasses (Employee Only) (once every 24 months)	100% up to $60	Not covered.

6. Life Insurance Benefits and Spousal Beneficiary Designation: Actives, Pre-Medicare Retirees, and Medicare Retirees (excluding Former Niles Participants, who do not have life insurance coverage)

Benefits will be provided through a ULLICO fully insured policy, as follows:

Active Employee:	Basic Life – Principal Sum	$15,000
	Accidental Death and Dismemberment Benefit	up to $15,000
Retiree :	Basic Life – Principal Sum	$5,000
	Accidental Death and Dismemberment Benefit	None

Spousal Beneficiary Designation: If a participant designates a spouse as their beneficiary, this will become null and void in the event of a divorce. The participant may re-designate the ex-spouse as the participant's beneficiary subsequent to divorce.

7. Weekly Disability Benefits: Actives

Weekly Disability benefits through the CMRCC Fund will be as follows:

Benefit Amount	$250 per week
Maximum Period of Payment Per Disability	26 weeks

8. Disability Related Provisions: Actives

- Definition of "Disabled": For purposes of eligibility credits and weekly disability benefits, the term "Disabled" under the terms of the CMRCC Fund will mean "a physical or mental condition, which in the opinion of a physician satisfactory to the Trustees, prevents a person from engaging in any regular occupation or employment for remuneration or profit for which contributions were received by the Plan prior to his/her disability. Notwithstanding, no person shall be deemed to have a Disability if such incapacity was contracted or incurred while he was engaged in an illegal activity or from service in the Armed Forces of any country."

- Self-Payments While Disabled After Bank is Exhausted: Disabled Participants will be permitted to make full self-payments for 12 consecutive months. However, 24 months of full self-payments will be permitted if they are seeking a Social Security Disability Award (SSD), and the participant made the application for SSD within 12 months of the onset of the Disability.

- Eligibility for Weekly Disability: To be eligible for Weekly Disability Benefits from the CMRCC Fund, an Active Employee must either: (1) be under the continuous care of a Physician who has provided a certification of Disability specifying the diagnosis, dates of Disability, and the date the Physician was first consulted for the Disability; or (2) submit a copy of a Social Security Disability award. In the Fund Office's sole discretion, additional certifications may be requested during the period of Disability and must be completed and returned to continue benefits.

9. Eligibility Provisions: Actives

- Small Bank Balances: Monthly Administrative Fees will no longer be taken from a Participant's Bank when the Bank balance is not enough to cover the monthly Premium (monthly cost of coverage). If contributions are not received for a consecutive 12-month period, the balance of the dollar bank will revert to the Fund.

- Self-Payments: Self-payments will be due the 25th of the month prior to the month for which the self-payment must be made to maintain eligibility. For example, if a self-payment is required for February eligibility, then the payment must be made by January 25th.

- Self-Payment Maximum: Active Participants will be allowed to make 12 consecutive full self-payments before being offered COBRA (if Disabled, see Disability Related Provisions: Active, above).

- Dollar Bank Freeze – A Participant's bank will be frozen upon application to the Fund if the Participant becomes employed a by a city, county, state government or International Union in a job classification normally covered by a CBA covering participants in the Plan, and is employed within the jurisdiction of the Fund, or is employed by the International Union.

- Delayed Eligibility: A newly eligible Participant may request a delayed eligibility start date where he or she has transferred to the CMRCC Fund and still has coverage under another UBC plan, provided he or she was not previously eligible in the CMRCC Fund.

- Accelerated Initial Eligibility: At the Trustees' discretion, an Employee may become eligible as of the first day on which Employer contributions are required to be paid on behalf of such Employee. The circumstances under which this initial eligibility rule will be applied will be the acceptance by the Trustees of newly organized bargaining units.

- Apprentice Eligibility: For any work month during which an Apprentice attends school required by a training program in which he/she is indentured and that is affiliated with the United Brotherhood of Carpenters and Joiners of America, his/her Bank will be credited with an amount equal to the Premium (monthly cost of coverage) minus the total Contributions actually received for such month, not to exceed the number of hours attended school times the current contribution rate for such apprentice.

- Termination of Eligibility: An Active Participant's coverage under the CMRCC Fund will terminate on the earliest of the following:

    - The last day of the month the Participant maintains eligibility via the Dollar Bank or self-payments;
    - The last day of the month a Participant begins active duty in the armed forces;
    - The date a Participant becomes employed by an employer who does not contribute to any fund sponsored by a Regional Council or Local Union of the United Brotherhood of Carpenters and Joiners of America and who employs individuals in a trade or craft covered by a CBA;
    - The date a Participant remains employed by an employer who no longer contributes to any fund sponsored by a Regional Council or Local Union of the United Brotherhood of Carpenters and Joiners of America and who employs individuals in a trade or craft covered by a CBA;
    - The date an Active Employee ceases Covered Employment and is not on the Union's out-of-work list; or
    - The date the Plan terminates.

  Notwithstanding, if a Participant stops working for a contributing Employer but continues to work under the terms of a Collective Bargaining Agreement of another affiliated Union of the United Brotherhood of Carpenters and Joiners of America, or continues to work for a contributing employer in a non-bargaining unit position, he will be covered so long as his Dollar Bank Account is sufficient to continue eligibility, and upon exhaustion of the Bank will be offered COBRA coverage.

10. Eligibility Provisions: Retirees

In addition to other applicable Plan provisions, to be eligible for Retiree coverage, a participant must meet these requirements:

(1) apply to the Plan for retiree coverage within 30 days of the last month in which he/she is eligible in the Plan as an Active Employee; and

(2) receive a defined benefit pension from a plan affiliated with the United Brotherhood of Carpenters and Joiners of America; and

(3) be a member of the Union in good standing (if your coverage under the Plan prior to retirement was based on Covered Employment as a bargaining unit member, which includes Union Employees who are alumni of the bargaining unit); and

(4) meet the requirements of (a) or (b), below, as applicable:

(a) former Ohio Participants, and all Plan participants as of January 1, 2027:

(i) must have been eligible in the Plan as an Active Employee immediately preceding retirement and in the following time frames immediately preceding retirement:

- for a total of 60 months in the last ten years; and
- 9 of the 12 months immediately preceding retirement; and

(ii) have not made more than 12 full or partial consecutive self-payment to continue Plan coverage in the year immediately preceding retirement (or 24 months if timely and actively pursuing a Social Security Disability Award); or

(b) former IKORCC Participants retiring before January 1, 2027:

must have been eligible in the Plan (or prior to 1/1/25, in the IKORCC Plan) as an Active Employee immediately preceding retirement and in the following time frames immediately preceding retirement:

- in the current month and the previous 23 months, or
- three consecutive months in each of the last three 24-month periods.

11. Hearing Benefits: Medicare Retirees and their Dependents

Hearing Benefits for Medicare Retirees and their Dependents will no longer be provided through Humana. The Plan will provide hearing benefits through TruHearing, the same as the benefits provided for Active participants. Subject to Plan limitations, the Plan will cover self-insured hearing aid benefits without any specific network as follows:

(a) Audiometric Examinations, Hearing Aid Evaluation Tests, Hearing Aids, and Hearing Aid Conformity Evaluations, once every four years for each ear and not to exceed a total of $3,000.00 every three years per Covered Person; and

(b) up to $250.00 annually to repair a Hearing Aid that is out of warranty.

A list of TruHearing Providers is available at www.truhearing.com**. Coverage will only be provided through a TruHearing Provider. Hearing aids and services will not be covered if obtained from out-of-network providers.**

12. Retiree Dependents

Retirees may add Dependents at any time on a prospective basis.

13. Medicare Retirees and Medicare Eligible Dependents Coverage in General

Except as set forth in this notice, benefits are not changing.

14. Non-Bargaining Unit Participation – Active, Life Insurance, Retiree Coverage

Active Employees: Subject to all Plan provisions, the following requirements must be met for the participation of Non-Bargaining Unit (NBU) employees of contributing employers:

(1) Execution of a Participation Agreement between the contributing employer and the Fund;

(2) The Employer has been a contributing Employer for at least 12 months prior to making application to cover NBU employees;

(3) On average for each 12-month period a Participation Agreement is in effect, at least 50% of the Employer's employees are individuals for whom Contributions are required under the CBA;

(3) The Employer covers all NBU who are working at least 32 hours a week for at least single coverage as of the first of the month following one month of employment, and is not allowed to cover those working less than 32 hours a week (notwithstanding, for Employers who were contributing on behalf of NBU employees under the Ohio Plan as of December 31, 2025, 24 hours will be substituted for 32 hours through December 31, 2026); and

(D) The Employer timely pays the monthly premium for coverage at the time and in the amount established in the sole and exclusive discretion of the Trustees. Premiums are due prior to the month of coverage. Coverage terminates in the event premiums are not timely remitted.

Life Insurance: NBU employees will be eligible for life insurance.

Retiree Coverage: Under the IKORCC Plan, NBU employees, if eligible, were allowed coverage as retirees (this was not allowed under the Ohio Plan). For NBU employees working for contributing employers who prior to January 1, 2025, contributed to the IKORCC plan, retiree coverage will be permitted under the terms of the IKORCC plan only for retirements on or before December 31, 2026, and afterwards no new NBU retirees will be allowed.

15. Plan Year Effective January 1, 2025

Effective January 1, 2025, the CMRCC Fund's Plan Year will be May 1 to the following April 30.

PLEASE BE ADVISED THAT THIS IS A SUMMARY OF BENEFITS. ALL STATEMENTS IN THIS NOTICE ARE SUBJECT TO ALL PLAN PROVISIONS, EXCLUSIONS, AND LIMITATIONS. IN THE EVENT OF ANY INCONSISTENCY BETWEEN THE TERMS OF THE PLAN AND THIS NOTICE, THE TERMS OF THE PLAN CONTROL.

W2766181

Central Midwest Regional Council of Carpenters' Welfare Fund

P.O. Box 1257, Troy, MI 48099
Phone: (800) 700-6756 - (855) 837- 3528

NOTICE OF CORRECTION

To: All Participants of the Ohio Carpenters Health Fund (Ohio Fund) and Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund (IKORCC Fund)

From: Boards of Trustees of the Ohio and IKORCC Funds

Date: November 1, 2024

Please be advised that the following correction is made to the chart included in Exhibit A, Section 1, of the enclosed Summary of Material Modification dated November 1, 2024.

Mental Health/Substance Use Disorder		
	IN-NETWORK	**OUT-OF-NETWORK**
Inpatient Residential Treatment Facility -60-day limit per year -Precertification required.	80% after deductible.	**Not Covered.**
Other Services		
Skilled Nursing Facility -Precertification Required -60-day visit limitation per year	80% after deductible.	**Not Covered.**

W2768761