Central Midwest Regional Council of Carpenters'
Welfare Fund

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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

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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.**

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