Central Midwest Regional Council of Carpenters' Welfare Fund

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

December 2024

IMPORTANT NOTICE

SHOP PLAN ELECTION FORM and SUMMARY OF BENEFITS AND COVERAGE

Dear Plan Participant:

This notice contains important information regarding coverage as a participant in the Central Midwest Regional Council of Carpenters' Welfare Fund. Please read this notice carefully. As a participant in the Shop plan, you are entitled to change your Plan coverage once per year. Shop Employees have the option to select between the Full Plan and the Shop Plan, which has reduced benefits at a lower cost.

Shop Election Form

Enclosed please find the election form the 2025 calendar year. The election form breaks down the cost of coverage for the Full Plan the Shop Plan. The coverage details for each plan are included in the mailing as the Summary of Benefits and Coverage.

Shop Employees will be able to elect one of the following options:

- **Coverage under the Full Plan (Plan 1**), at a cost of $1,150.00 per month (same cost single or family). This plan includes dental, vision, and hearing coverage.

- **Coverage under the Shop Plan (Plan 2**), at a cost of $500 per month single or $850 per month family. **This plan does not include dental, vision, and hearing coverage.**

Important Note: Out of pocket costs for participants are higher under the Shop Plan, and there is NO COVERAGE for prescription drugs, dental, hearing, vision, or Medical Reimbursement Account, which is why it costs less than the Full Plan.

Please complete the election form and return it to the Fund Office at the address on the form on or before January 10, 2025. **IF THIS FORM IS NOT RETURNED, for 2025, you will be enrolled in the same coverage you had for 2024.**

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Welfare Fund

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Summary of Benefits and Coverage

Enclosed please find the Summary of Benefits and Coverage ("SBC") for both the Full and Shop plans, which is provided annually.

The Summary of Benefits and Coverage includes three parts:

- Benefits and Coverage Information
- Coverage Examples
- Questions and Answers about Coverage Examples

Benefits and Coverage Information

This section includes a chart that lists various features of the Plan's medical coverages. It also provides information about coverage for different covered services, such as office visits, prescription drugs, and emergency room services.

Coverage Examples/Questions and Answers

The coverage examples on the SBC show how the Fund might cover medical care for three specific scenarios, and address frequently asked questions regarding coverage examples. The examples show what the Fund would pay and what the patient would pay based on a common set of assumptions. It is important to note that these are examples only. They should not be used to estimate your actual costs under the Plan.

If you have any questions regarding the content of this notice, or your coverage in general, please contact the Fund Office at (800) 700-6756.

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Welfare Fund

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SHOP PLAN ELECTION FORM

Rates Effective 7/1/2024

MEDICAL BENEFITS (choose only one):

	Single Coverage	Family Coverage
SHOP PLAN	**$500.00 _____**	**$850.00 _____**
FULL PLAN	**$1,150.00 _____**	**$1,150.00 _____**

By signing this form, I acknowledge that I have reviewed the enclosed information. I also understand that regardless of my election, the Plan encourages participants to use providers (doctors, hospitals, etc.) that participate in the Fund's network, and this will result in lower out of pocket costs to me and my family. I also understand that my election cannot be changed until the next calendar year unless I have a qualifying event, such as marriage or a new dependent.

Participant's Name: _____
(Print)

Participant's Signature: _____

Participant's Social Security #: _____

Date: _____

Return this form in the enclosed envelope or mail to: CMRCC Welfare Fund
P.O. Box 1257
Troy, MI 48099

Forms can also be returned via email at: **enrollmentdocs@benesys.com**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (855) 837-3528. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call (855) 837-3528 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $500/individual or $1,000/family Out-of-Network: $500/individual or $1,250 family *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible unless the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network Preventive Care and Dental Preventive Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Dental Benefits - $100 each calendar year. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**In-Network** Medical: $3,500/individual or $7,000/family Prescription: $5,700/individual or $11,400/family **Out-of-Network** Medical: $5,000/individual or $10,000/family Prescription: No limit *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Out-of-network charges in excess of plan allowances, premiums, balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes*. See www. ibxtpa.com or call (833) 242-3330 for a list of network providers. **Out-of-Network providers* may be treated as *In-Network providers* as required by No Surprises Act.*	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network not subject to deductible. Teladoc – no copayment, deductible or coinsurance. Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc.
	Specialist visit	$40 copayment/visit		----------none----------
	Preventive care/screening/ immunization	No charge	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network providers not subject to the deductible. Plan covers preventive services and supplies required by ACA. Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	----------none----------
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** contact the Fund Office at(855) 837-3528.	Generic drugs	Retail - $20 copayment/ prescription (for 1st 3 fills of same drug); 100% up to $100 copayment/ prescription (for 4th or more fills of same drug) Smart 90 / Mail Order - $50 copayment/prescription	Submit original receipts to Fund Office for reimbursement, which will not exceed the amount the Fund would have paid an in-network pharmacy.	Maintenance drugs must be filled through the Smart 90 Retail or Mail Order Program. Retail is up to 90-day supply. Mail Order is up to 90-day supply. If generic equivalent is available; you will be required to pay the price difference between the generic drug and the preferred brand name drug unless Physician requests brand-name drug. Clinical programs for some classes of drugs include prior authorization, step therapy, and/or quantity limits. Certain weight loss drugs may be covered.
	Preferred drugs	Retail - $40 copayment/ prescription (for 1st 3 fills of same drug); 100% up to $100 copayment/ prescription (for 4th or more fills of same drug) Smart 90 / Mail Order - $100 copayment/prescription		
	Non-Preferred brand drugs	Retail - $80 copayment/ prescription (for 1st 3 fills of same drug); 100% up to $100 copayment/ prescription (for 4th or more fills of same drug) Smart 90 / Mail Order - $200 copayment/prescription		
	Specialty drugs	25% coinsurance up to $200		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	----------none----------
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 copayment/visit, then 25% coinsurance after deductible	$250 copayment/visit, then 25% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	$250 copayment waived if the patient is admitted to the hospital or if the reason for the visit to the emergency room is due to an accidental injury or life-threatening condition.
	Emergency medical transportation	20% coinsurance after deductible	Ground: 40% coinsurance based on Applicable Medicare Rate after deductible Air: 20% coinsurance (lesser of billed charges or the Qualified Payment Amount) unless otherwise required by No Surprises Act	To and from the hospital for a covered inpatient admission or initial treatment of an Emergency Medical Condition provided by a hospital or a government-certified ambulance service.
	Urgent care	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Teladoc – no copayment, deductible or coinsurance. Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate.
	Physician/surgeon fees			----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Teladoc – no copayment, deductible or coinsurance. Teladoc is an In-Network Benefit only – no coverage for any telemedicine program other than Teladoc. Care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a licensed social worker.
	Inpatient services		40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Prior authorization required. Residential Treatment Facility covered in-network only and limited to 60 days per year.
If you are pregnant	Office visits	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Maternity care may include tests and services described elsewhere in this document (i.e., ultrasound). Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance or a deductible may apply. Pregnancy of a dependent child not covered.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			Inpatient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery. Pregnancy of a dependent child not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Limit 40 visits per year.
	Rehabilitation services			----------none----------
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% coinsurance after deductible	Not covered	Prior authorization required. Limit 60 days per calendar year.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Includes rental fees not to exceed purchase price. Expenses for special fittings, adaptations, maintenance, or repairs are not covered.
	Hospice services			Must be provided at freestanding hospice facility or by a hospice program sponsored by a hospital or Home Health Care Agency. Hospice services may be received in a private residence.
If your child needs dental or eye care	Children's eye exam	No charge for children up to age 19		Limited to once every 12 months.
	Children's glasses	No charge for medically necessary services for children up to age 19		Limited to once every 24 months.
	Children's dental check-up	No charge for preventive services up to age 19		Cleanings and exams limited to two per year. Preventive dental services are not subject to dental deductible.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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

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

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

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al (855) 837-3528.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf (855) 837-3528 uff.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

DELTA DENTAL®

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

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

Control Plan – Delta Dental of Ohio

Benefit Year – January 1 through December 31

Covered Services –

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

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

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

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

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

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

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

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

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

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

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

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

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

vsp vision care

Make Eye Health a Priority with VSP!

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

VSP members save an annual average of

$471*

More Ways to Save

Extra $20 to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

Up to 40% Savings on lens enhancements‡

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

Enroll through your employer today. Questions?

vsp.com or **800.877.7195**

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network eye doctor can detect signs of over 270 health conditions during an eye exam.**

Savings you'll love.

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

The choice is yours!

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Save up to $250 on Featured Frame Brands when you shop on Eyeconic®, the VSP online eyewear store.

Getting started is easy!

Let your plan do the most it can. When you create an account on **vsp.com**, you can view your in-network coverage details, find a VSP network doctor that is right for you, and discover extra savings to maximize your benefits.

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

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

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

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

Classification: Restricted

Your VSP Vision Benefits Summary

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

Provider Network:
VSP Choice
Effective Date:
01/01/2025

vsp vision care

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

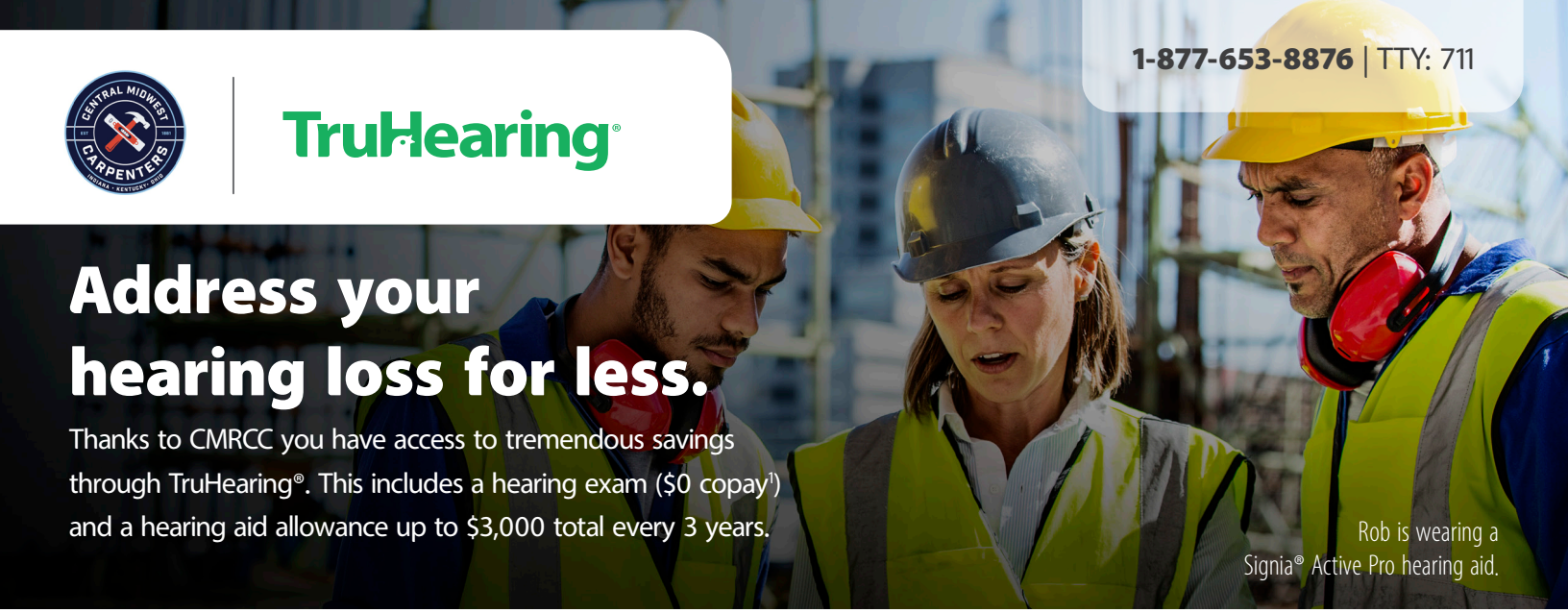
GET MORE AT PREFERRED IN-NETWORK LOCATIONS

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

TruHearing®

Address your hearing loss for less.

Thanks to CMRCC 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/CMRCC

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. 576258-1-1124

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (855) 837-3528. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call (855) 837-3528 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network*: $1,750/individual / $3,500/family Out-of-Network: $3,500/individual / $7,000/family *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible unless the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	In-Network Wellness & Preventive Services and Teladoc Doctor Visit are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain in-network preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network*: – $7,350/individual / $14,700/family Out-of-Network: $10,000/individual / $20,000/family *Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.*	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, non-network cost sharing, health care this plan doesn't cover, charges in excess of reasonable and customary and penalties for failing to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes*. See www.ibxtpa.com or call (833) 242-3330 for a list of network providers. **Out-of-Network providers* may be treated as *In-Network providers* as required by No Surprises Act.*	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network not subject to deductible. Teladoc Program - no copayment, deductible or coinsurance. Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
	Specialist visit	$40 copayment/visit		In-network not subject to deductible.
	Preventive care/screening/ Immunization	No charge	Not covered	Coverage available in-network only. Immunizations available from any allowed providers, including pharmacies. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 copayment/visit, then 25% coinsurance after deductible	$250 copayment/visit, then 25% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Copayment waived if patient is admitted to the hospital or if visit is due to an injury or life-threatening event.
	Emergency medical transportation	25% coinsurance after deductible	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	----------none----------
	Urgent care	25% coinsurance after deductible	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	In-network not subject to deductible. Teladoc Program - no copayment, deductible or coinsurance. Teladoc is an in-network benefit only – no coverage for a telemedicine program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after deductible	45% coinsurance based on Applicable Medicare Rate after deductible unless otherwise required by No Surprises Act	Benefits based on hospital's average semi-private room rate. Precertification required.
	Physician/surgeon fees			----------none----------

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

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services and limitations of coverage.)

- Acupuncture
- Cosmetic surgery (unless medically necessary)
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Prescription drugs
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these and other covered services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (if Plan guidelines are met)
- Chiropractic care (25 visits per year)
- Non-emergency care when traveling outside the U.S. (see www.bcbsglobalcore.com)
- Private-duty nursing

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

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

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al (855) 837-3528.

Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf (855) 837-3528 uff.

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

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

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

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

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

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

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

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

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

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

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

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

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