



Central Midwest Regional Council of Carpenters' Welfare Fund

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

December 2024

IMPORTANT NOTICE – SUMMARY OF BENEFITS AND COVERAGE

MEDICARE ADVANTAGE RETIREES

Dear Plan Participant:

This notice contains important information regarding coverage as a participant in the Central Midwest Regional Council of Carpenters' Welfare Fund. Included are SBCs outlining your medical benefits with Humana Group Medicare Advantage through Retiree First, Delta Dental, VSP, and TruHearing. Please read this notice carefully.

Effective January 1, 2025, Medicare Retirees and their Dependents can elect Dental and Vision Benefits for an additional \$25 monthly self-payment per person. Please return the election form enclosed in this packet to the benefits office as soon as possible to enroll in Dental and Vision benefits.

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.

Summary of Benefits and Coverage

Enclosed please find your Summary of Benefits and Coverage ("SBC"), 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 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.



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?	\$0	See the Common Medical Events chart below for your costs for services this plan covers. This is a Medicare Advantage plan.
Are there services covered before you meet your deductible?	Not Applicable	This plan does not have a deductible . This is a Medicare Advantage plan.
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. This is a Medicare Advantage plan.
What is the out-of-pocket limit for this plan?	Medical: \$1,000/individual Rx: \$2,000/individual for formulary drugs covered by Medicare	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 .
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network . You can receive covered services from any provider .
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	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge		-----none-----
	<u>Specialist</u> visit	No charge		-----none-----
	<u>Preventive care/screening/immunization</u>	No charge		-----none-----
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge		-----none-----
	Imaging (CT/PET scans, MRIs)	No charge		-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provide	Out-of-Network Provider	
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 31-day supply: \$10 copayment /prescription Retail 60-day supply: \$20 copayment /prescription Retail 90-day supply: \$30 copayment /prescription Mail Order 90-day supply: \$20 copayment /prescription		Retail is up to 90-day supply. Mail Order is 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 prescription notes "dispense as written."
	Preferred brand drugs	Retail 31-day supply: \$30 copayment /prescription Retail 60-day supply: \$60 copayment /prescription Retail 90-day supply: \$90 copayment /prescription Mail Order 90-day supply: \$60 copayment /prescription		
	Non-preferred brand drugs	Retail 31-day supply: \$75 copayment /prescription Retail 60-day supply: \$150 copayment /prescription Retail 90-day supply: \$225 copayment /prescription Mail Order 90-day supply: \$150 copayment /prescription		
	Specialty drugs	Retail 31-day supply: \$100 copayment /prescription Retail 60-day supply: \$200 copayment /prescription Retail 90-day supply: \$300 copayment /prescription Mail Order 90-day supply: \$200 copayment /prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		-----none-----
	Physician/surgeon fees	No charge		-----none-----
If you need immediate medical attention	Emergency room care	\$65 copayment /visit		\$65 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 injury or sickness.
	Emergency medical transportation	No charge		-----none-----
	Urgent care	No charge		-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provide	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge up to the Medicare Allowed Amount per Medicare benefit period, 100% of charges once Medicare is exhausted.		-----none-----
	Physician/surgeon fees			-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge		-----none-----
	Inpatient services	No charge		-----none-----
If you are pregnant	Office visits	No charge		-----none-----
	Childbirth/delivery professional services	No charge		-----none-----
	Childbirth/delivery facility services	No charge		-----none-----
If you need help recovering or have other special health needs	Home health care	No charge		-----none-----
	Rehabilitation services	No charge		-----none-----
	Habilitation services	No charge		-----none-----
	Skilled nursing care	No charge for the first 100 days. 100% of charges for day 101 and beyond.		-----none-----
	Durable medical equipment	No charge		-----none-----
	Hospice services	No charge		-----none-----
If your child needs dental or eye care	Children's eye exam	No coverage.		No coverage under Medicare Advantage Plan, but coverage under Active Plan. See Active SBC.
	Children's glasses	No coverage.		No coverage under Medicare Advantage Plan, but coverage under Active Plan. See Active SBC.
	Children's dental check-up	No coverage.		No coverage under Medicare Advantage Plan, but coverage under Active Plan. See Active SBC.

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	• Long-term care	• Routine foot care
• Cosmetic surgery (unless <u>medically necessary</u>)	• Non-emergency care when traveling outside the U.S. (see www.bcbsglobalcore.com)	• Weight loss programs (ESI weight loss program only)
• Infertility treatment		

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

• Bariatric surgery (if <u>Plan</u> guidelines are met)	• Dental care (adult)	• Private-duty nursing (if <u>Plan</u> guidelines are met)
• Chiropractic care	• Hearing aids (up to \$3,000 every 3 years)	• 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](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), 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 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](http://Marketplace.gov) 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](http://Marketplace.gov).

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	\$0 ¹
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments ²	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

¹ Assumes member is using a Medicare provider.

² [Copayments](#) apply to prescriptions.

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0 ¹
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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	\$5,300
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In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments ²	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$320

¹ Assumes member is using a Medicare provider.

² [Copayments](#) apply to prescriptions.

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0 ¹
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$70

¹ Assumes member is using a Medicare provider.

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

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.

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■ Other coinsurance	0%

This EXAMPLE event includes services like:

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

Total Example Cost

\$12,700

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Deductibles	\$0
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The total Peg would pay is	\$70

¹ Assumes member is using a Medicare provider.

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Managing Joe's Type 2 Diabetes

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

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■ Other coinsurance	0%

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

\$5,300

In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments ²	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
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[Diagnostic test](#) (*x-ray*)
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Total Example Cost

\$2,800

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Deductibles	\$0
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Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
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¹ Assumes member is using a Medicare provider.

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



TruHearing®

1-877-653-8876 | TTY: 711

Address your hearing loss for less.

Thanks to CMRCC you have access to tremendous savings through TruHearing®. This includes a hearing exam (\$0 copay¹) 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



The right hearing aids can change your life.

Research shows that addressing hearing loss can impact your overall health and well-being, including improvements in²

- 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.

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Central Midwest Regional Council of Carpenters' Welfare Fund

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

Former Ohio Carpenters' Health Fund

OPTIONAL DENTAL/VISION BENEFITS ENROLLMENT (OPT-IN) FORM

Retired Participants: Retirees on Medicare, Surviving Spouses, Disabled Retirees, and Eligible Dependents

Print or Type

Part I. Participant Information

Last Name	First Name	M	Date of Birth	Soc. Sec. No. or Alternate ID. No.
MM/DD/YEAR				
Street Address		Apt.		
City	State	Zip Code	Marital Status	
Single	Divorced			
Married	Widowed			
Area Code and Telephone Number	Email Address			

Part II. Coverage Selection

DELTA DENTAL / VSP VISION Benefits

Yes, I wish to Opt-In of Dental/Vision coverage for myself and all dependents on the policy (\$25.00 single person, \$50.00 participant and dependents)	<input type="checkbox"/>
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Part III. Authorization: I understand that I have elected to enroll myself and my eligible Dependents in the above Optional Dental Plan and Vision Plan under Delta Dental and VSP. I understand that the increased amount of my self-payment will be determined according to the eligible Dependents I have listed under the Ohio Carpenters Health Fund. The increase in my self-payment will become effective the month following receipt of form, (if you have Pension Deduction for your health care premium, the Dental/ Vision premium will be added to that amount, or if you do not, you will see the increase on your monthly self-payment notice). **I also understand that if I fail to enroll at this time or if I do enroll but subsequently cease my participation therein, I shall not be given another opportunity to participate.**

Participant Signature _____ **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



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.

Make Eye Health a Priority with VSP!

Your health comes first with VSP and Central Midwest Regional Council of Carpenters Health 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!



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.



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.

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Classification: Restricted

Your VSP Vision Benefits Summary

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

Provider Network:

VSP Choice

Effective Date:

01/01/2025



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness Routine retinal screening 	\$10 Up to \$39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	<ul style="list-style-type: none"> 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			
FRAME*	<ul style="list-style-type: none"> \$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	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children 	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> \$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	<ul style="list-style-type: none"> Exam to determine safety eyewear needs 	\$0	Every 12 months
FRAME*	<ul style="list-style-type: none"> \$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	<ul style="list-style-type: none"> 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	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> 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. <p>Laser Vision Correction</p> <ul style="list-style-type: none"> Average of 15% off the regular price; discounts available at contracted facilities. <p>Exclusive Member Extras for VSP Members</p> <ul style="list-style-type: none"> 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			
<p>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.</p>			