CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100 ✧ P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com

October 9, 2015

TO: **All Active Plan B and Flat Rate Participants and their Dependents, including COBRA Beneficiaries**

FROM: **BOARD OF TRUSTEES**
Carpenters Health and Welfare Trust Fund for California

RE: **BENEFIT CHANGES**
- **Changes to Deductible and Out-of-Pocket Maximum**
- **Enhancement to the Vision Service Plan (VSP) Provider Network**

EFFECTIVE JANUARY 1, 2016, the Board of Trustees of the Carpenters Health and Welfare Trust Fund for California modified Plan Rules and Regulations to the annual Deductible and Out-of-Pocket amounts for Active Participants and Dependents.

CALENDAR YEAR DEDUCTIBLE:

The Deductible is the amount of covered expenses that you pay each calendar year before the Plan begins to pay benefits.

The Indemnity medical plan deductible amount depends on whether you use Contract or Non-Contract Providers, as shown in the chart below. The chart also shows at what point you will be considered to have met the annual Deductible for everyone in your family (**Note:** Only expenses that have actually been applied to a family member's per person Deductible will count toward the family Deductible*)*.

Effective January 1, 2016, your Calendar Year Deductible will be changed as described below:

Calendar Year Deductible	Contract Provider		Non-Contract Provider	
	Before 1/1/2016	Effective 1/1/2016	Before 1/1/2016	Effective 1/1/2016
Per Person	$100	$128	$200	$257
Maximum Per Family	$200	$256	$400	$514

Amounts cross-accumulate between Contract and Non-Contract Providers–for example, a $50 deductible applied to a Non-Contract Provider for Covered Expenses would count toward the $128 deductible for Contract Providers.

Charges exceeding any Plan limits on specific benefits and any amounts above the Plan allowable do not count toward the deductible.

OUT-OF-POCKET LIMIT:

The Out-of-Pocket limit is the most you pay in coinsurance for covered medical expenses in a calendar year before the Plan begins to pay 100% of the coinsurance. Under the medical plan, if you use Contract Providers, once you have met the Out-of-Pocket limit for covered expenses during a calendar year, the Plan will pay 100% of the coinsurance for most covered services for the rest of that calendar year. The following chart shows the point at which the Out-of-Pocket limit is considered to be reached for you and your family.

Calendar Year Out-of-Pocket Limit	Contract Provider		Non-Contract Provider	
	Before 1/1/2016	Effective 1/1/2016	Before 1/1/2016	Effective 1/1/2016
Per Person	$5,000	$6,445	None	None
Maximum Per Family	$10,000	$12,890	None	None

The following do not count toward the Out-of-Pocket Limit:

- Amounts you pay that are counted toward a deductible
- Amounts you pay for expenses or services that are not covered by the Plan
- Charges in excess of benefit limits or Plan maximums (such as chiropractic care, acupuncture, hearing aids, hospice care, and routine physical examinations.)

VISION SERVICE PLAN (VSP) / COSTCO:

For Participants eligible under the Indemnity Plan, vision care benefits are administered by VSP. VSP has a network of providers who receive the highest benefits available under the plan. **Beginning January 1, 2016**, VSP will expand their network of providers to include wholesale chain, Costco.

To access VSP benefits at Costco, no identification card is necessary. At your appointment, tell the Costco representative you have VSP and they will handle the rest. There are no claim forms to complete to access your network benefit.

Grandfathered Health Plan: The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California believes the Fund's medical plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plan, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plans to change from grandfathered health plan status can be directed to the plan administrator or the Department of Labor at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform*. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

Please keep this notice with your benefit booklet. If you have any questions, please contact Benefit Services at the Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an e-mail to benefitservices@carpenterfunds.com. Forms and information can be found on our website at www.carpenterfunds.com.

The Board of Trustees maintains the right to change or discontinue the types and amounts of benefits under this Plan. This notice is intended as a summary only, and actual Plan documents will be used to interpret the Plan. Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of any benefits payable to you. No individual Trustee, Employer or Union Representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan.