



# Carpenters Health & Welfare Trust Fund for California

## Plan A & R Comparison

| <b>QUICK REFERENCE</b>   |   |
|--|---|
| Information Needed:  | Contact the Following:  |
| Eligibility, Benefits, COBRA, Disability, or Life and Accidental Death and Dismemberment Claims (AD&D)   | Fund Office (510) 633-0333 or<br>Toll Free (888) 547-2054   |
| Claims:<br>Indemnity Medical Plan<br>Orthodontic Benefit (Indemnity & Kaiser)<br>Indemnity Hearing Aid Benefit   | Fund Office (510) 633-0333 or<br>Toll Free (888) 547-2054<br><a href="http://www.carpenterfunds.com">www.carpenterfunds.com</a> |
| Contract Provider Program – In California<br>(Indemnity Medical Plan)  | Fund Office (510) 633-0333 or<br>Toll Free (888) 547-2054<br><a href="http://www.anthem.com/ca">www.anthem.com/ca</a>           |
| Contract Provider Program – Outside California<br>(Indemnity Medical Plan)   | BlueCard (800) 810-2583<br><a href="http://www.bluecares.com">www.bluecares.com</a>   |
| Review Organization for Required Pre-Authorizations – In or Outside California<br>(Indemnity Medical Plan)   | Anthem Blue Cross (800) 274-7767  |
| Prescription Drug Benefits<br>(Indemnity Medical Plan)   | Medco (800) 939-7093<br><a href="http://www.medco.com">www.medco.com</a><br>Fund Office (888) 547-2054                          |
| Vision Service Plan<br>(Indemnity Medical Plan)  | (800) 877-7195<br><a href="http://www.vsp.com">www.vsp.com</a>  |
| Kaiser Permanente  | (800) 464-4000<br><a href="http://my.kp.org/ca/carpenterfunds/index.html">http://my.kp.org/ca/carpenterfunds/index.html</a>     |
| Delta Dental (Delta Preferred Option)  | (800) 765-6003<br><a href="http://www.deltadentalca.org">www.deltadentalca.org</a>  |
| PacifiCare Behavioral Health<br>Mental Health (Indemnity only)<br>Alcohol & Chemical Dependency (Indemnity & Kaiser)<br>Member Assistance Program (Indemnity & Kaiser) | (877) 225-2267<br><a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a>  |

Please note: This summary is a brief description of Carpenters Health and Welfare Plan benefits. In all cases, the Plan Rules and Regulations, including any amendments, will be the basis for the payment of any benefits.

| BENEFITS                                  | KAISER  | INDEMNITY  |
|---|---|--|
| Plan Selections                           | A Health Maintenance Organization (HMO) that provides prepaid medical, drug, vision and hearing aid benefits to Participants enrolled in this Plan with a guaranteed payment of these benefits. Participants must live within the Service Area. | The Indemnity Plan is a comprehensive benefit plan with an annual deductible and a limit on your annual out of pocket for covered expenses. After the out of pocket limit is reached each year, the Plan will pay 100% of covered expenses for the remainder of the calendar year.   |
| Phantom COB<br>(Coordination of Benefits) | Phantom COB does not apply  | Phantom COB: If the participant's spouse is employed and the employer offers insurance, the spouse must elect coverage. If he or she declines coverage, the Indemnity Plan will pay up to 20% of covered medical bills. The Fund will estimate the benefits of the other group plan at 80% of expenses incurred and will coordinate its benefits with the estimated benefits.      |
| Annual Deductible                         | None  | Per person: PPO: \$100, Non-PPO: \$200<br>Maximum deductible Per family:<br>PPO: \$200, Non-PPO: \$400   |
| Annual out of Pocket Limits               | Limit on co-payments<br>Per person - \$1,500<br>Per family - \$3,000  | For Contract Providers, \$1,000 per person, not to exceed \$2,000 per family.<br><b>There is no Out of Pocket Maximum for Non-Contract Provider charges.</b>   |
| Co-Payments                               | Shown for each service  | Once annual deductible is satisfied and until the out of pocket limit is met, the Plan pays PPO at 90% of contract rates and Non-PPO at 70% of Allowed Charges for all benefits unless otherwise indicated.  |
| Plan Lifetime Maximum                     | None  | \$2,000,000  |
| Choice of Physicians                      | Members choose a Physician on staff at a Kaiser Permanente facility located in their service area. Routine, preventive, and specialist care are provided at Kaiser Permanente facilities or by Kaiser contract providers.                       | Members may use the providers of their choice; however to receive maximum benefits, members must use PPO/contract providers.   |
| Hospital Services                         | No Charge   | Inpatient: Subject to deductibles and out of pocket limits. Benefits reduced by 25% if utilization review is not obtained. Outpatient: Subject to deductibles and out of pocket limits. PPO - 90% Non-PPO - 70%; however, if there was no choice in the hospital used due to an Emergency and patient was admitted from the Emergency Room, the benefit is 90% of Allowed Charges. |

**BENEFITS****KAISER****INDEMNITY**

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| Hospital Emergency Room | \$50 per visit, waived if admitted to hospital.                       | Subject to deductibles and annual out of pocket limits. PPO: paid at 90% Non-PPO: paid at 70%; however, if there was no choice in the hospital used due to an Emergency, the benefit is 90% of Allowed Charges. |
| Physician Office Visits | \$20 per visit  | Subject to deductibles and annual out of pocket limits. PPO: paid at 90% Non-PPO: paid at 70%   |
| Surgical Services       | No Charge for inpatient; \$20 per procedure for outpatient surgery    | Subject to deductibles and annual out of pocket limits. PPO: paid at 90% Non-PPO: paid at 70%   |
| X-rays & Lab            | No Charge   | Subject to deductibles and annual out of pocket limits. PPO: paid at 90% Non-PPO: paid at 70%   |
| Maternity               | \$5 per visit for scheduled prenatal care and first post partum visit | Subject to deductibles and annual out of pocket limits. PPO: paid at 90% Non-PPO: paid at 70%   |
| Sterilization Benefits  | Co-payment required   | Subject to deductibles and annual out of pocket limits. PPO: paid at 90% Non-PPO: paid at 70%   |
| Ambulance               | No Charge   | Subject to deductibles and annual out of pocket limits.<br>PPO: paid at 90%<br>Non-PPO: paid at 90% Allowed Charge  |

**PREVENTIVE CARE**

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| Adult Physical Exam                                      | \$20 per visit   | For Participant and Spouse only. The following benefits are subject to plan deductibles and are paid at 90% PPO or 70% Non-PPO: Adult physical limited to \$250 in any 12-month period. Out of pocket limits do not apply to charges in excess of the benefit limits. Colonoscopy, Sigmoidoscopy, Mammograms and PSA test for Participants age 50 and over are covered at 90% of contract rates for PPO or 70% Allowed Charge for Non-PPO. |
| Well Child Care/Routine Physicals for Dependent Children | \$5 per visit up to age two, \$20 per visit age two and over | Subject to deductible and annual out of pocket limits.<br>PPO: paid at 90%<br>Non-PPO: paid at 70%<br>For children over age 2, benefits are limited to one physical examination in any 12-month period.  |

**BENEFITS****KAISER****INDEMNITY**

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| Female Routine Exam           | \$20 per visit                                     | See “Adult Physical Exam” above. For Participant/Spouse only. Services limited to \$250 in combination with adult physical exam in any 12-month period. Subject to deductibles and out of pocket limits. Additional allowance for a pap smear. |
| Immunization                  | No Charge (Adults & Children)                      | Dependent children only. Subject to deductibles and annual out of pocket limits. PPO: paid at 90%<br>Non-PPO: paid at 70%  |
| Allergy Testing and Treatment | \$20 per testing visit; \$3.00 per injection visit | Subject to deductibles and annual out of pocket limits. PPO: paid at 90%<br>Non-PPO: paid at 70%   |

**MENTAL HEALTH CARE**

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| Inpatient, Partial and Day Treatment                           | No charge, up to 45 days per calendar year.<br>This benefit is provided by Kaiser, not PacifiCare.   | Provided by PacifiCare Behavioral Health.<br>In-Network - 90%, no deductible.<br>Out-of-Network - 40% of Allowed Charge, no deductible 20 days maximum per calendar year (combined maximum for in-network and out-of-network).<br>All services must be pre-authorized or no benefits will be payable.<br>Days are determined based on the following ratios:<br>Inpatient treatment - 1 day<br>Residential treatment - 70% of 1 day<br>Day Treatment - 60% of 1 day |
| Outpatient   | \$20 individual / \$10 group visits<br>Limited to 20 visits per year.<br>This benefit is provided by Kaiser, not PacifiCare.   | Provided by PacifiCare Behavioral Health.<br>In-Network - \$20 copay per visit<br>Out-of-Network - 50% of Allowed Charge, no deductible 20 visits maximum per calendar year (combined in-network and out-of-network maximum)   |
| Severe Mental Illness/Serious Emotional Disturbance of a Child | For Serious Mental Illness, there is no limit on the number of days or outpatient visits.<br>Severe Mental Illness diagnoses include: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive Compulsive Disorder, Pervasive Developmental Disorders (Autism), Anorexia, Bulimia Nervosa, Serious Emotional Disturbances of Children (SED) | In-Network Inpatient - 90%, no deductible, unlimited days.<br>In-Network Outpatient - \$20 copay per visit, unlimited visits. All treatment must be pre-authorized or no benefits are payable.<br><b>Out-of-Network - Not a covered benefit.</b>   |

**BENEFITS****KAISER****INDEMNITY**


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**ALCOHOL & CHEMICAL DEPENDENCY TREATMENT  
PROVIDED BY PACIFICARE BEHAVIORAL HEALTH (PBH)**

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| All levels of Chemical Dependency Care (including detoxification) | In-Network Only - \$0 copay, covered at 100%. Requires prior authorization. | In-Network - 100%, no deductible<br>Out-of-Network - 50%, no deductible<br>All services must be pre-authorized or no benefits are payable. |
| Annual Maximum  | \$25,000  | \$25,000   |
| Lifetime Maximum  | \$35,000  | \$35,000   |

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**MEMBER ASSISTANCE PROGRAM (MAP) -  
PROVIDED BY PACIFICARE BEHAVIORAL HEALTH (PBH)**

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|   |  |   |
|---|--|---|
| Counseling Sessions with a <b>PBH network counselor</b> | 3 visits per incident at \$0 copay (In-Network) counseling and community resources referrals (No Deductible) | 3 visits per incident at \$0 copay (In-Network) counseling, community resources referrals (No Deductible) |
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**OTHER MEDICAL SERVICES**

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|---|--|--|
| Home Health Care                                    | No Charge, up to 100 visits per calendar year  | Subject to deductibles and annual out of pocket limits. PPO: paid at 90%<br>Non-PPO: paid at 70%   |
| Skilled Nursing Facilities                          | No Charge; Limited to 100 days per benefit period.   | Subject to deductibles and annual out of pocket limits.<br>PPO: paid at 90%<br>Non-PPO: paid at 70%<br>Limited to 70 days per period of confinement.<br>Utilization review recommended.              |
| Short Term Therapy (Physical, Speech, Occupational) | \$20 per visit   | Subject to deductibles and annual out of pocket limits. PPO: paid at 90%<br>Non-PPO: paid at 70%   |
| Chiropractic  | Self-referral; must use network providers; \$10 per visit, limited to 30 visits per year. \$50 allowance per calendar year on Chiropractic appliances. | Benefit for Participant and Spouse only. Maximum payment of \$25 per visit and 20 visits per calendar year. Subject to deductibles. Out of pocket limits do not apply to charges over plan maximums. |
| Acupuncture   | Available with referral  | Maximum payment of \$35 per visit and 20 visits per calendar year. Subject to deductibles. Out of pocket limits do not apply to charges over plan maximums.  |
| Podiatry  | \$20 per visit   | Subject to deductibles and annual out of pocket limits. PPO: paid at 90%<br>Non-PPO: paid at 70%   |
| Durable Medical Equipment                           | No Charge  | Subject to deductibles and annual out of pocket limits. PPO: paid at 90%<br>Non-PPO: paid at 70%   |

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**BENEFITS****KAISER****INDEMNITY****VISION BENEFITS**

|                            |  |   |
|----------------------------|--|---|
| Vision Exam                | \$20 per visit, must use Kaiser Optical  | Vision exam through Vision Service Signature Choice Plan every 12 months after \$10 co-payment for exam.  |
| Glasses and Contact Lenses | Must use Kaiser Optical. Maximum allowance of \$125 for glasses or contact lenses. Benefit renews every 24 months. | Covered through Vision Service Signature Choice Plan after \$25 co-payment for materials. Provides one pair of lenses every 12 months and frames every 24 months. Visually Necessary contact lenses paid in full if provided by a VSP doctor. For other elective contact lenses, Plan pays up to a \$105 allowance for professional fees and materials. |

**PRESCRIPTION DRUGS**

|                             |  |  |
|-----------------------------|--|--|
| Retail Pharmacy             | <p>\$10 for generic drug<br/>         \$30 for formulary brand drug<br/>         Prescriptions from Non-Kaiser providers (other than Dentists) are NOT covered.<br/>         Maximum 100-day supply.</p>   | <p>Retail contract pharmacies only, unless there are none within 10 miles.<br/>         \$10 for formulary generic drug<br/>         \$10, PLUS cost difference between generic and brand for multi-source brand.<br/>         \$40 for single source formulary brand.<br/>         \$60 for non-formulary - Certain non-formulary drugs are not covered without prior authorization.<br/>         30-day supply<br/>         All prescription drug benefits limited to a maximum payment of \$75,000 per eligible individual per calendar year.</p> |
| Mail Order                  | <p>\$10 for generic drug<br/>         \$30 for formulary brand drug Maximum 100-day supply.<br/>         Mail orders on reorder prescriptions only. Call your local Kaiser Pharmacy for further details or see Kaiser's website at <a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a> Prescriptions from Non-Kaiser providers (other than Dentists) are NOT covered.</p> | <p>\$20 for formulary generic drug.<br/>         \$20 PLUS cost difference between generic and brand for multi-source brand.<br/>         \$80 for single source formulary brand.<br/>         \$100 for non-formulary.<br/>         Certain non-formulary drugs are not covered without prior authorization.<br/>         90-day supply.<br/>         All prescription drug benefits limited to a maximum payment of \$75,000 per eligible individual per calendar year.</p>  |
| Hearing Exam & Hearing Aids | \$20 per visit; \$2,500 maximum for each hearing aid. Hearing aids are provided every 36 months.   | Maximum benefit limits: 100%, up to \$800 maximum for each ear, including the exam only if the hearing aid(s) is obtained. Hearing aids provided every 3 years. (Not subject to deductibles or out of pocket limits.)  |
| Coverage Areas              | See attached page for a zip code listing of covered areas.   | PPO/Contract facilities available throughout California and the U.S. Call 1(888) 547-2054 to verify contract providers in California, or 1 (800) 810-2583 for contract providers outside California  |

**BENEFITS****KAISER****INDEMNITY**

|                                  |  |   |
|----------------------------------|--|---|
| Where to go for more information | 1(800) 464-4000<br><a href="http://www.kaiserpermanente.org">http://www.kaiserpermanente.org</a> | Trust Fund Office<br>1(888)547-2054 or 1(510) 633- 0333<br><a href="http://www.carpenterfunds.com">www.carpenterfunds.com</a> |
|----------------------------------|--|---|

**DENTAL BENEFITS - FOR KAISER & INDEMNITY PARTICIPANTS**

|                                      |   |
|--------------------------------------|---|
| In-Network: Delta Dental PPO Dentist | Maximum - \$2,500 per patient per calendar year<br>Diagnostic & Preventive - 100% Contract Rate<br>Basic Services - 80% Contract Rate<br>Crowns & Cast Restorations - 80% Contract Rate<br>Prosthodontics - 80% Contract Rate |
| Outside of Delta Dental PPO Network  | Maximum - \$2,000 per patient per calendar year<br>Diagnostic & Preventive - 100% Contract Rate<br>Basic Services - 50% Contract Rate<br>Crowns & Cast Restorations - 50% Contract Rate<br>Prosthodontics - 50% Contract Rate |
| Maximum                              | The maximum benefit is \$2,500 per year, reduced to \$2,000 for services of Non-PPO dentists. The above maximums are not separate maximums.   |

**ORTHODONTIC BENEFITS**

|   |  |
|---|--|
| Orthodontic Benefits for Dependent Children | Benefits covered by Indemnity Medical Plan, not Delta Dental. Plan pays 50% of covered charges to a maximum of \$1,500 per dependent child to the age of 19. |
|---|--|

**DEFINITIONS**

|  |   |
|--|---|
| Generic                                | A drug identified by its chemical name - an equivalent version of a brand name drug whose exclusive patent has expired.                           |
| Multi-Source Brand                     | A brand name drug that has a generic equivalent.  |
| Single Source Formulary Brand          | A brand name drug that has no generic equivalent and is placed on a list of preferred formulary drugs by the pharmacy benefit manager.            |
| Non-Formulary Drug                     | A drug that is NOT on a list of preferred formulary drugs.  |
| Allowed Charge                         | The dollar amount the Fund has determined it will allow for covered Medically Necessary services or supplies performed by Non-Contract Providers. |
| Phantom COB (Coordination of Benefits) | If the participant's spouse is employed and the employer offers insurance, the spouse must elect coverage.  |

## Kaiser Service Areas

|          |          |          |          |          |          |          |          |          |
|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| 90001-84 | 91046    | 91778    | 92274-78 | 92801-09 | 93599    | 94199    | 95020-21 | 95436    |
| 90086-91 | 91066    | 91780    | 92282    | 92811-12 | 93601-02 | 94203-09 | 95026    | 95439    |
| 90093-96 | 91077    | 91784-86 | 92284-86 | 92814-17 | 93604    | 94211    | 95030-33 | 95441-42 |
| 90101    | 91101-10 | 91788-93 | 92305    | 92821-23 | 93606-07 | 94229    | 95035-38 | 95444    |
| 90103    | 91114-18 | 91795    | 92307-08 | 92825    | 93609    | 94230    | 95042    | 95446    |
| 90189    | 91121    | 91801-03 | 92313-18 | 92831-38 | 93611-14 | 94232    | 95044    | 95448    |
| 90201-02 | 91123-26 | 91901-03 | 92320-22 | 92840-46 | 93616    | 94234-37 | 95046    | 95450    |
| 90209-13 | 91129    | 91908-17 | 92324-26 | 92850    | 93618-19 | 94239    | 95050-56 | 95452    |
| 90220-24 | 91182    | 91921    | 92329    | 92856-57 | 93623-27 | 94240    | 95070-71 | 95462    |
| 90230-32 | 91184-85 | 91931-33 | 92331    | 92859-61 | 93630-31 | 94244    | 95101    | 95465    |
| 90239-42 | 91188-89 | 91935    | 92333-37 | 92863    | 93636-39 | 94246-50 | 95103    | 95471-73 |
| 90245    | 91199    | 91941-47 | 92339-41 | 92865-71 | 93643-46 | 94252    | 95106    | 95476    |
| 90247-51 | 91201-10 | 91950-51 | 92344-46 | 92877-83 | 93648-54 | 94254    | 95108-13 | 95486    |
| 90254-55 | 91214    | 91962-63 | 92350    | 92885-87 | 93656-57 | 94256-59 | 95115-36 | 95487    |
| 90260-67 | 91221-22 | 91976-80 | 92352    | 92899    | 93660    | 94261-63 | 95138-41 | 95492    |
| 90270    | 91224-26 | 91987    | 92354    | 93001-07 | 93662    | 94267-69 | 95148    | 95602-05 |
| 90272    | 91301-11 | 92007-11 | 92357-59 | 93009-12 | 93666-69 | 94271    | 95150-61 | 95607-21 |
| 90274-75 | 91313    | 92013-14 | 92369    | 93015-16 | 93673    | 94273-74 | 95164    | 95623-26 |
| 90277-78 | 91316    | 92018-27 | 92371-78 | 93020-22 | 93675    | 94277    | 95170    | 95628    |
| 90280    | 91319-22 | 92029-30 | 92382    | 93030-36 | 93701-12 | 94279-80 | 95172-73 | 95630    |
| 90290-96 | 91324-31 | 92033    | 92385-86 | 93040-44 | 93714-18 | 94282-91 | 95190-94 | 95632-35 |
| 90301-10 | 91333-35 | 92037-40 | 92391-95 | 93060-66 | 93720-30 | 94293-98 | 95196    | 95638-41 |
| 90312    | 91337    | 92046    | 92397    | 93094    | 93741    | 94301-06 | 95201-13 | 95645    |
| 90401-11 | 91340-46 | 92049    | 92399    | 93099    | 93744-45 | 94309    | 95215    | 95648    |
| 90501-10 | 91350-62 | 92051-52 | 92401-08 | 93203    | 93747    | 94401-04 | 95219-20 | 95650-52 |
| 90601-10 | 91364-65 | 92054-58 | 92410-15 | 93205-06 | 93750    | 94497    | 95227    | 95655    |
| 90620-24 | 91367    | 92064-65 | 92418    | 93215-16 | 93755    | 94501-03 | 95230-31 | 95658-64 |
| 90630-33 | 91371-72 | 92067-69 | 92423-24 | 93220    | 93760-61 | 94505-31 | 95234    | 95667-74 |
| 90637-40 | 91376-77 | 92071-72 | 92427    | 93222    | 93764-65 | 94533-53 | 95236-37 | 95676-78 |
| 90650-52 | 91380-81 | 92074-75 | 92501-09 | 93224-26 | 93771-80 | 94555-83 | 95240-42 | 95680-83 |
| 90660-62 | 91383-87 | 92078-79 | 92513-19 | 93230    | 93784    | 94585-92 | 95253    | 95686-88 |
| 90670    | 91390    | 92081-85 | 92521-22 | 93232    | 93786    | 94595-99 | 95258    | 95690-98 |
| 90680    | 91392-96 | 92090-93 | 92530-32 | 93238    | 93790-94 | 94601-15 | 95267    | 95703    |
| 90701-03 | 91401-13 | 92096    | 92543-46 | 93240-43 | 93844    | 94617-24 | 95269    | 95722    |
| 90706-07 | 91416    | 92101-24 | 92548    | 93249-52 | 93888    | 94649    | 95296-97 | 95736    |
| 90710-17 | 91423    | 92126-32 | 92551-57 | 93261    | 94002    | 94659-62 | 95304    | 95741-42 |
| 90720-21 | 91426    | 92134-40 | 92562-64 | 93263    | 94005    | 94666    | 95307    | 95746-47 |
| 90723    | 91436    | 92142-43 | 92567    | 93268    | 94010    | 94701-10 | 95313    | 95757-59 |
| 90731-34 | 91470    | 92145    | 92570-72 | 93276    | 94011    | 94712    | 95316    | 95762-63 |
| 90740    | 91482    | 92147    | 92581-87 | 93280    | 94013-28 | 94720    | 95319-20 | 95765    |
| 90742-49 | 91495-96 | 92149-50 | 92589-93 | 93285    | 94030    | 94801-08 | 95323    | 95776    |
| 90755    | 91499    | 92152-55 | 92595-96 | 93287    | 94035    | 94820    | 95326    | 95798    |
| 90801-10 | 91501-08 | 92158-79 | 92599    | 93301-09 | 94037-44 | 94850    | 95328-30 | 95799    |
| 90813-15 | 91510    | 92182    | 92602-07 | 93311-14 | 94060-66 | 94901    | 95336-37 | 95811-38 |
| 90822    | 91521-23 | 92184    | 92609-10 | 93380    | 94070    | 94903    | 95350-58 | 95840-43 |
| 90831-35 | 91601-12 | 92186-87 | 92612    | 93383-90 | 94074    | 94904    | 95360-61 | 95851-53 |
| 90840    | 91614-18 | 92190-93 | 92614-20 | 93501-02 | 94080    | 94912-15 | 95363    | 95860    |
| 90842    | 91701-02 | 92195-99 | 92623-30 | 93504-05 | 94083    | 94920    | 95366-68 | 95864-67 |
| 90844    | 91706    | 92201-03 | 92637    | 93510    | 94085-89 | 94922-25 | 95376-78 | 95894    |
| 90846-47 | 91708-11 | 92210-11 | 92646-63 | 93518-19 | 94101-05 | 94927-31 | 95380-82 | 95899    |
| 90848    | 91715-16 | 92220    | 92672-79 | 93531-32 | 94107-12 | 94933    | 95385-87 | 95903    |
| 90853    | 91722-24 | 92223    | 92683-85 | 93534-36 | 94114-34 | 94937-42 | 95391    | 95961    |
| 90895    | 91729-35 | 92230    | 92688    | 93539    | 94137    | 94945-57 | 95397    |          |
| 91001    | 91737    | 92234-36 | 92690-94 | 93543-44 | 94139    | 94960    | 95401-07 |          |
| 91003    | 91739-41 | 92240-41 | 92697-98 | 93550-53 | 94140-47 | 94963-66 | 95409    |          |
| 91006-12 | 91743-50 | 92247-48 | 92701-08 | 93560-61 | 94151    | 94970-79 | 95416    |          |
| 91016-17 | 91752    | 92252-56 | 92711-12 | 93563    | 94156    | 94999    | 95419    |          |
| 91020-21 | 91754-56 | 92258    | 92728    | 93581    | 94158-64 | 95002    | 95421    |          |
| 91023-25 | 91758-59 | 92260-64 | 92735    | 93584    | 94172    | 95008-09 | 95425    |          |
| 91030-31 | 91761-73 | 92268    | 92780-82 | 93586    | 94177    | 95011    | 95430-31 |          |
| 91040-43 | 91775-76 | 92270    | 92799    | 93590-91 | 94188    | 95013-15 | 95433    |          |