



Carpenters Health & Welfare Trust Fund for California

Comparison for Plan B & Flat Rate Benefits

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

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 Areas.	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 (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 Maximum Deductible Per family: PPO: \$200, Non-PPO: \$400
Annual Out of Pocket Limits	Per person - \$1,500 Per family - \$3,000	Per Person: PPO: \$5,000; Non-PPO: \$20,000 Per Family PPO: \$10,000 Non-PPO: No limit
Cost Share	Shown for each service	Once annual deductible is satisfied and until the out of pocket limit is met, the Plan pays: PPO at 80% of contract rates and Non-PPO at 60% of C & R (Customary and Reasonable) 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.

BENEFITS**KAISER****INDEMNITY**

Hospital Services	\$250 per admission	Inpatient: Subject to deductibles and out of pocket limits. Hospital and physician benefits reduced by 25% if utilization review is not obtained. PPO: 80% Non-PPO: 60%, 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 80% of Customary and Reasonable charges.
Hospital Emergency Room	\$100 per visit (waived if admitted)	Subject to deductibles and annual out of pocket limit. PPO: paid at 80%; Non-PPO: paid at 60%, however, if there was no choice in the hospital used due to an Emergency, the benefit is 80% of Customary and Reasonable charges.
Physician Office Visits	\$20 per visit	Subject to deductibles and annual out of pocket limits. PPO: paid at 80%, Non-PPO: paid at 60%
Surgical Services	\$20 per procedure (Outpatient)	Subject to deductibles and annual out of pocket limits. PPO: paid at 80%, Non-PPO: paid at 60%
X-rays & Lab	No charge	Subject to deductibles and annual out of pocket limits. PPO: paid at 80%, Non-PPO: paid at 60%
Maternity	\$5 per visit for scheduled prenatal visits and first postpartum visit; \$250 hospital admission copay for delivery.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80%, Non-PPO: paid at 60%
Ambulance	No charge	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 80% C&R

PREVENTIVE CARE

Adult Physical Exam	No charge.	The following benefits are subject to plan deductibles and are paid at 80% PPO or 60% Non-PPO: Adult physical limited to \$250 each year. (Dependent Children NOT covered for physical exam.) Out of pocket limits do not apply to charges in excess of the benefit limits. Colonoscopy, Sigmoidoscopy, Mammograms and PSA test covered at contract rates for PPO or C&R for Non-PPO, paid at 80% PPO, 60% Non-PPO. PSA covered for participants age 50 and over.
---------------------	------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

BENEFITS	KAISER	INDEMNITY
Well Child Care	Ages 0-23 months: \$5 per visit. After age 2: \$20 per visit.	Covered up to age two only, subject to deductible and out of pocket limits, paid at 80% PPO or 60% Non-PPO.
Female Routine Exam	\$15 per visit. No charge for family planning visits.	See "Adult Physical Exam" above. For Participant/Spouse only. Exam limited to \$250 in combination with adult physical exam each year. Subject to deductibles and out of pocket limits. Additional allowance for a pap smear.
Immunization	No Charge.	Dependent Children only. Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Allergy Testing and Treatment	\$15 per testing visit, \$3.00 per injection visit. Subject to deductibles and out of pocket limits.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%

MENTAL HEALTH BENEFITS

Inpatient, Partial and Day Treatment	\$250 per admission (up to 45 days per calendar year)	Benefit provided by PacifiCare Behavioral Health. In-Network - 90%, no deductible. Out-of-Network - 40% of C&R, no deductible. 20 days maximum per calendar year (combined maximum for in-network and out-of-network). All services must be pre-authorized or no benefits will be payable.
Outpatient	\$20 individual / \$10 group visit (up to 20 visits combined per calendar year)	Benefit provided by PacifiCare Behavioral Health. In-Network - \$20 copay per visit Out-of-Network - 50% of C&R, 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	The mental health copays and visit/day limits shown above do not apply to severe mental illness or serious emotional disturbances of a child. Services for these conditions are covered on the same basis as a medical condition. (\$250 copay for inpatient hospital; \$20 copay for office visits)	In-Network Inpatient - 90%, no deductible, unlimited days. In-Network Outpatient - \$20 copay per visit, unlimited visits. All treatment must be pre-authorized or no benefits are payable. Out-of-Network - Not a covered benefit

ALCOHOL & CHEMICAL DEPENDENCY TREATMENT PROVIDED BY PACIFICARE BEHAVIORAL HEALTH

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

BENEFITS	KAISER	INDEMNITY
Annual Maximum	\$25,000	\$25,000
Lifetime Maximum	\$35,000	\$35,000
MEMBER ASSISTANCE PROGRAM (MAP) - PROVIDED BY PACIFICARE BEHAVIORAL HEALTH		
Counseling Sessions with a PBH network counselor	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 - Pre-authorization required), community resources referrals (No Deductible)
OTHER MEDICAL SERVICES		
Home Health Care	No charge (up to 100 visits per calendar year).	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Skilled Nursing Facilities	No charge (up to 100 visits per calendar year).	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60% Limited to 70 days per period of confinement. Utilization review is recommended.
Short Term Therapy (Physical, Speech, Occupational)	\$20 per visit.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Chiropractic	Self-referral; must use network providers. \$10 per visit, limited to 30 visits per year.	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. Subject to deductibles and out of pocket limits.	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 out of pocket limits.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Durable Medical Equipment	No charge.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
VISION BENEFITS		
Vision Exam	Eye exam: \$20 per visit Eyewear: \$125 allowance every 2 years Must use Kaiser Optical.	Vision exam through Vision Service Signature Choice Plan every 12 months after \$10 copay.

BENEFITS**KAISER****INDEMNITY**

Glasses and Contact Lenses

Maximum allowance of \$125 for glasses or contact lenses. Benefit renews every 24 months.

Covered through Vision Service Signature Choice Plan after \$25 copay 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 if from a VSP doctor, subject to \$10 exam copay.

PRESCRIPTION DRUGS

Retail Pharmacy

Generic Retail:
\$10 (30 days)
\$20 (31-100 days)
Brand Retail:
\$30 (30 days)
\$60 (31-100 days)
Prescriptions from Non-Kaiser providers (other than Dentists if the drug is for dental care) or other than prescriptions obtained in conjunction with covered emergency care or out-of-area urgent care are NOT covered.

\$10 for formulary generic drug
Retail contract pharmacies only, unless there are none within 10 miles.
\$10, PLUS cost difference between generic and brand for multi-source brand.
\$40 for single source formulary brand.
\$60 for non-formulary - Certain non-formulary drugs are not covered without prior authorization. 30 day supply. Prescription drug benefits limited to a maximum Plan payment of \$75,000 per eligible individual, per calendar year.

Mail Order

Generic Mail Refills:
\$20 (100 days)
Brand Mail Refills:
\$30 (30 days)
\$60 (31-100 days)
Mail orders on reorder prescriptions only. Visit www.kp.org for information on obtaining refills.
Prescriptions from Non-Kaiser providers (other than Dentists) are NOT covered.

\$20 for formulary generic drug.
\$20 PLUS cost difference between generic and brand for multi-source brand.
\$80 for single source formulary brand.
\$100 for non-formulary. Certain non-formulary drugs are not covered without prior authorization. 90-day supply. Prescriptions for more than a 30-day supply must be filled through the mail order program. Prescription drug benefits limited to a maximum Plan payment of \$75,000 per eligible individual, per calendar year.

Hearing Exam & Hearing Aids

\$20 copay for exam.
Plan pays: \$2,500 allowance per device.
One device per ear every 36 months.

Maximum benefit limits: 100%, up to \$800 maximum for each ear, including the exam only if the hearing aid(s) are 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.

Where to go for more information

1(800) 464-4000
<http://my.kp.org/ca/carpenterfunds/index.html>

Trust Fund Office 1(888)547-2054 or 1(510) 633- 0333
<http://www.carpenterfunds.com>

DENTAL BENEFITS - FOR KAISER & INDEMNITY PARTICIPANTS

In-Network: Delta Dental PPO Dentist	Maximum - \$2,500 per patient per calendar year Diagnostic & Preventive - 100% Contract Rate Basic Services - 80% Contract Rate Crowns & Cast Restorations - 80% Contract Rate Prosthodontics - 80% Contract Rate
Dentists outside of Delta Dental PPO Network	Maximum - \$2,000 per patient per calendar year Diagnostic & Preventive - 100% Contract Rate Basic Services - 50% Contract Rate Crowns & Cast Restorations - 50% Contract Rate 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.
C&R	Customary and reasonable
Phantom COB (Coordination of Benefits)	If the participant's spouse is employed and the employer offers insurance, the spouse must elect coverage.

Kaiser Zip Codes

90001-84	90895	91510	92081-85	92418	93040-44	93618	94232	95044	95425
90086-89	90899	91521-23	92090-93	92423	93060-66	93619	94234-37	95046	95430
90091	91001	91526	92096	92424	93093	93623-27	94239	95050-56	95431
90093-96	91003	91601-12	92101-24	92427	93094	93630	94240	95070	95433
90099	91006-12	91614-18	92126-40	92501-09	93099	93631	94244-50	95071	95436
90101-03	91016	91701	92142	92513-19	93203	93636-39	94252	95101	95439
90189	91017	91702	92143	92521	93205	93643-46	94254	95103	95441
90201	91020	91706	92145	92522	93206	93648-54	94256-59	95106	95442
90202	91021	91708-11	92147	92530-32	93215	93656	94261-63	95108-13	95444
90209-13	91023-25	91714-16	92149	92543-46	93216	93657	94267-69	95115-36	95446
90220-24	91030	91722-24	92150	92548	93220	93660	94271	95138-41	95448
90230-33	91031	91729-35	92152-55	92551-57	93222	93662	94273	95148	95450
90239-42	91040-43	91737	92158-79	92562-64	93224-26	93666-69	94274	95150-61	95452
90245	91046	91739-41	92182	92567	93230	93673	94277-80	95164	95462
90247-51	91066	91743-50	92184	92570-72	93232	93675	94282-91	95170	95465
90254	91077	91752	92186	92581-87	93238	93701-12	94293-99	95172	95471-73
90255	91101-10	91754-56	92187	92589-93	93240-43	93714-18	94301-06	95173	95476
90260-67	91114-18	91758	92190-99	92595		93720-30	94309	95190-94	95486
90270	91121	91759	92201-03	92596		93740-41	94401-04	95196	95487
90272	91123-26	91761-73	92210	92599		93744	94497	95201-13	95492
90274	91129	91775-76	92211	92602-07	93250-52	93745	94501-03	95215	95602-05
90275	91131	91778	92220	92609	93261	93747	94505-31	95219	95607-21
90277	91182	91780	92223	92610	93263	93750	94533-53	95220	95623-26
90278	91184	91784-86	92230	92612	93268	93755	94555-83	95227	95628
90280	91185	91788-93	92234-36	92614-20	93276	93760	94585-92	95230	95630
90290-96	91188	91795	92240	92623-30	93280	93761	94595-99	95231	95632-35
90301-13	91189	91797-99	92241	92637	93285	93764	94601-15	95234	95638-41
90397	91191	91801-04	92247	92646-63	93287	93765	94617-25	95236	95645
90398	91199	91841	92248	92672-79	93301-09	93771-80	94649	95237	95648
90401-11	91201-10	91896	92252-56	92683-85	93311-14	93784	94659-62	95240-42	95650-52
90501-10	91214	91899	92258	92688	93380-90	93786	94666	95253	95655
90601-10	91221	91901-03	92260-64	92690-94	93501	93790-94	94701-10	95258	95658-64
90612	91222	91908-17	92268	92697	93502	93844	94712	95267	95667-74
90620-24	91224-26	91921	92270	92698	93504	93888	94720	95269	95676-78
90630-33	91301-11	91931-33	92274-78	92701-12	93505	94002	94801-08	95296	95680-83
90637-40	91313	91935	92282	92725	93510	94005	94820	95297	95686-88
90650-52	91316	91941-47	92284-86	92728	93518	94010	94850	95304	95690-98
90659-62	91319-22	91950	92292	92735	93519	94011	94901	95307	95703
90670	91324-31	91951	92305	92780-82	93531	94013-28	94903	95313	95722
90671	91333-35	91962	92307	92799	93532	94030	94904	95316	95736
90680	91337	91963	92308	92801-09	93534-36	94035	94912-15	95319	95741
90701-03	91340-46	91976-80	92313-18	92811	93539	94037-44	94920	95320	95742
90706	91350-65	91987	92320-22	92812	93543	94060-66	94922-31	95323	95746
90707	91367	91990	92324-26	92814-17	93544	94070		95326	95747
90710-17	91371	92007-11	92329	92821-23	93550-53	94074	94933	95328-30	95757-59
90720	91372	92013	92331	92825	93560	94080	94937-42	95336	95762
90721	91376	92014	92333-37	92831-38	93561	94083	94945-57	95337	95763
90723	91377	92018-30	92339-41	92840-46	93563	94085-89	94960	95350-58	95765
90731-34	91380-88	92033	92344-46	92850	93581	94101-12	94963-66	95360	95776
90740	91390	92037-40	92350	92856	93584	94114-47	94970-79	95361	95798
90742-49	91392-96	92046	92352	92857	93586	94150-56	94998-99	95363	95799
90755	91399	92049	92354	92859-71	93590	94158-64	95002	95366-68	95811-38
90801-10	91401-13	92051	92357-59	92877-83	93591	94171-72	95008	95376-78	95840-43
90813-15	91416	92052	92369	92885-87	93599	94175	95009	95380-82	95851-53
90822	91423	92054-58	92371-78	92899	93601	94177	95011	95385-87	95860
90831-35	91426	92064	92382	93001-07	93602	94188	95013-15	95391	95864-67
90840	91436	92065	92385	93009-12	93604	94199	95020	95397	95887
90842	91470	92067-69	92386	93015	93606	94203-09	95021	95401-07	95894
90844-48	91482	92071	92391-95	93016	93607	94211	95026	95409	95899
90853	91495-97	92072	92397	93020-22	93609	94229	95030-33	95416	95903
90888	91499	92074	92399	93030-36	93611-14	94230	95035-38	95419	95961
	91501-08	92075	92401-08		93616		95042	95421	
		92078-79	92410-15						