



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 Claims (AD&D)	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 Mental Health (Indemnity only) Alcohol & Chemical Dependency (Indemnity & Kaiser) Member Assistance Program (Indemnity & Kaiser)	(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	Limit on co-payments Per person - \$1,500 Per family - \$3,000	For Contract Providers, \$5,000 per person, not to exceed \$10,000 per family. There is no Out of Pocket Maximum for Non-Contract Provider charges.
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 Allowed Charge 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	\$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 Allowed Charges.

BENEFITS	KAISER	INDEMNITY
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 Allowed 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% Allowed Charge
PREVENTIVE CARE		
Adult Physical Exam	\$20 per visit.	The following benefits are subject to plan deductibles and are paid at 80% PPO or 60% 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 covered at contract rates for PPO or Allowed Charge for Non-PPO, paid at 80% PPO, 60% Non-PPO. PSA covered for participants age 50 and over.
Well Child Care/Routine Physicals for Dependent Children	Ages 0-23 months: \$5 per visit. After age 2: \$20 per visit.	Subject to deductible and out of pocket limits, paid at 80% PPO or 60% Non-PPO. For children over age 2, benefits are limited to one physical examination in any 12-month period.
Female Routine Exam	\$20 per visit. \$20 for family planning visits.	See "Adult Physical Exam" above. For Participant/Spouse only. Exam 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.

BENEFITS	KAISER	INDEMNITY
Immunization	No Charge. (Adults & Children)	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	\$20 per testing visit, \$3.00 per injection visit.	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 Allowed Charge, 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) This benefit is provided by Kaiser, not PacifiCare.	Benefit provided by PacifiCare Behavioral Health. In-Network - \$20 copay per visit 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	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 (PBH)		
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.
Annual Maximum	\$25,000	\$25,000
Lifetime Maximum	\$35,000	\$35,000

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

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)
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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%
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Skilled Nursing Facilities	\$250 per admission (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.
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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%
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Chiropractic	Self-referral; must use network providers. \$10 per visit, limited to 30 visits per year. \$50 allowance per calendar year for 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.
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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.
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Podiatry	\$20 per visit.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
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Durable Medical Equipment	No charge.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
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VISION BENEFITS

Vision Exam	Eye exam: \$20 per visit Must use Kaiser Optical.	Vision exam through Vision Service Signature Choice Plan every 12 months after \$10 copay.
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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.

PRESCRIPTION DRUGS

Retail Pharmacy

Generic Retail:
 \$10 (30 days)
 \$20 (31-60 days)
 \$30 (61-100 days)
 Brand Retail:
 \$30 (30 days)
 \$60 (31-60 days)
 \$90 (61-100 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:
 \$10 (30 days)
 \$20 (31-100 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.
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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	