



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 members.kp.org
Delta Dental (Delta Preferred Option)	(800) 765-6003 www.deltadentalca.org
OptumHealth Behavioral Solutions Mental Health (Indemnity only) Alcohol & Chemical Dependency (Indemnity & Kaiser) Member Assistance Program (Indemnity & Kaiser)	(877) 225-2267 www.liveandworkwell.com

Healthcare Reform: Carpenters Health and Welfare Trust Fund for California believes this Plan is a “grandfathered health plan” 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 plans, for example, the requirement for the provision of preventive 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 plan to change from grandfathered health plan status can be directed to the Plan Administrator at 265 Hegenberger Rd., Suite 100, Oakland, CA 94621. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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. Allowed Charge: The dollar amount the Fund has determined it will allow for covered Medically Necessary services or supplies performed by Non-Contract Providers.
Medical & Prescription Drug Annual Maximum Benefit	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 Allowed 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 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.	For Participant and Spouse only. Subject to deductibles and annual out of pocket limits. PPO: paid at 80%, Non-PPO: paid at 60%
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.	For Participant and Spouse only. Subject to deductibles and annual out of pocket limits. PPO: paid at 80%, Non-PPO: paid at 60%
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%

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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 OptumHealth Behavioral Solutions. 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 OptumHealth Behavioral Solutions.	Benefit provided by OptumHealth Behavioral Solutions. 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 OPTUMHEALTH BEHAVIORAL SOLUTIONS		
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.
MEMBER ASSISTANCE PROGRAM (MAP) - PROVIDED BY OPTUMHEALTH BEHAVIORAL SOLUTIONS		
Counseling Sessions with an Optum-Health network counselor	3 visits per incident at \$0 copay (In-Network - Pre-authorization required), 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%

BENEFITS	KAISER	INDEMNITY
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.
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. \$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.
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 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 Must use Kaiser Optical.	Vision exam through Vision Service Signature Choice Plan every 12 months after \$10 copay.
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.

BENEFITS**KAISER****INDEMNITY****PRESCRIPTION DRUGS**

Retail Pharmacy	<p>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.</p>	<p>\$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.</p>
Mail Order	<p>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.</p>	<p>\$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. Maintenance Prescriptions must be filled through the mail order program.</p>
Prescription Drug Terminology	<p>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.</p>	
Hearing Exam & Hearing Aids	<p>\$20 copay for exam. Plan pays: \$2,500 allowance per device. One device per ear every 36 months.</p>	<p>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.)</p>
Coverage Areas	<p>See attached page for a zip code listing of covered areas.</p>	<p>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.</p>
Where to go for more information	<p>1(800) 464-4000 members.kp.org</p>	<p>Trust Fund Office 1(888)547-2054 or 1(510) 633- 0333 www.carpenterfunds.com</p>

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. *Maximum does not apply to dependent children under age 19.

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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Kaiser Service Areas

93230	94102-94105	94850	95269	95638-95641
93232	94107-94112	94901	95296-95297	95645
93242	94114-94134	94903-94904	95304	95648
93601-93602	94137	94912-94915	95307	95650-95652
93604	94139-94147	94920	95313	95655
93606-93607	94151	94922-94931	95316	95658-95664
93609	94156	94933	95319	95667-95674
93611-93614	94158-94164	94937-94942	95320	95676-95678
93616	94172	94945-94957	95323	95680-95683
93618-93619	94177	94960	95326	95686-95687
93623-93627	94188	94963-94966	95328	95688
93630-93631	94199	94970-94979	95329-95330	95690-95698
93636-93639	94203-94209	94999	95336-95337	95703
93643-93646	94211	95002	95350-95358	95722
93648-93654	94229-94230	95008-95009	95360-95361	95736
93656-93657	94232	95011	95363	95741-95742
93660	94234-94237	95013-95015	95366-95368	95746-95747
93662	94239-94240	95020-95021	95376-95378	95757-95759
93666-93669	94244	95026	95380-95382	95762-95763
93673	94246-94250	95030-95033	95385-95387	95765
93675	94252	95035-95038	95391	95776
93701-93712	94254	95042	95397	95798-95799
93714-93718	94256-94259	95044	95401-95407	95811-95838
93720-93730	94261-94263	95046	95409	95840-95843
93737	94267-94269	95050-95056	95416	95851-95853
93741	94271	95070-95071	95419	95860
93744-93745	94273-94274	95076	95421	95864-95867
93747	94277	95101	95425	95894
93750	94279-94280	95103	95430-95431	95899
93755	94282-94291	95106	95433	95903
93760-93761	94293-94298	95108-95113	95436	95961
93764-93765	94301-94306	95115-95136	95439	
93771-93779	94309	95138-95141	95441-95442	
93786	94401-94404	95148	95444	
93790-93794	94497	95150-95161	95446	
93844	94501-94503	95164	95448	
93888	94505-94531	95170-95173	95450	
94002	94533-94553	95190-95194	95452	
94005	94555-94583	95196	95462	
94010-94011	94585-94592	95201-95213	95465	
94014-94028	94595-94599	95215	95471-95473	
94030	94601-94624	95219-95220	95476	
94035	94649	95227	95486-95487	
94037-94044	94659-94662	95230-95231	95492	
94060-94066	94666	95234	95602-95605	
94070	94701-94710	95236-95237	95607-95621	
94074	94712	95240-95242	95623-95626	
94080	94720	95253	95628	
94083	94801-94808	95258	95630	
94085-94089	94820	95267	95632-95635	