CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
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May 30, 2008

TO: All Active Plan B and Flat Rate Plan Participants

FROM: Board of Trustees
Carpenters Health and Welfare Trust Fund for California

RE: Termination of United Healthcare Dental (Pacific Union Dental) Plan
Indemnity Medical Plan Out-of-Pocket Maximum Change
Kaiser Medical Plan Change

In September 2007, in an effort to lower the amount of money to be allocated to the health plan, the Dental benefits were modified. Under most agreements this resulted in money that was previously earmarked for health and welfare being allocated by the bargaining parties to the hourly wage. Also, because Kaiser's premium has steadily increased over the years, the cost of Kaiser is now considerably higher than the cost of Plan B Indemnity.

Many Plan B Participants notified the Fund Office that the new dental plan did not meet their needs. Those participants requested that the dental plan be changed back to Delta Dental, even if to offset the additional cost for Delta Dental other benefits had to be adjusted. In response to those requests, and in an effort to more closely balance the cost of Kaiser and Indemnity benefits, the following changes have been made:

Effective July 1, 2008 (For Plan B Participants Only)

- **DELTA DENTAL BENEFIT TO REPLACE United Healthcare Dental (Pacific Union Dental) Plan.** The United Healthcare Dental (Pacific Union Dental) Plan will be terminated for Plan B participants. This plan will be replaced by the same Delta Dental plan you had before September 1, 2007. Enclosed is the Delta Dental Evidence of Coverage booklet.

Effective January 1, 2009 (For Plan B and Flat Rate Plan Participants)

- **Indemnity Medical Plan Out-of-Pocket Maximum**. Under the Indemnity Medical plan, the annual out-of-pocket limit for PPO providers will be reduced from $10,000 to $5,000 with a family out-of-pocket maximum of $10,000 for PPO providers only. The annual out-of-pocket limit for non-PPO providers will remain at $20,000.

- **Kaiser Medical Plan**. The Kaiser benefits will change to a plan with a $150 annual deductible. Please refer to the attached benefit summary for more detailed information regarding the new deductibles, co-payments and coinsurance.

Please keep this notice with your benefit booklet. If you have any questions, please call the Benefits Department at the Trust Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an e-mail to benefitservices@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.

Carpenters Health and Welfare Trust Fund for California
Kaiser Benefit Summary – Plan B and Flat Rate Participants

	CURRENT KAISER PLAN	NEW KAISER PLAN EFFECTIVE 1/1/09
ANNUAL OUT-OF-POCKET MAXIMUM	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
ANNUAL DEDUCTIBLE	None	$150 Individual $450 maximum per family
YOUR COPAYMENTS:		
PRIMARY CARE OFFICE VISIT	$20 per visit	$15 per visit
PHYSICAL EXAM	$20 per visit	$0 per visit
PREVENTIVE SERVICES	$20 per visit	$15 per visit
WELL-CHILD PREVENTIVE CARE (0-23 MONTHS)	$5 per visit	$0 per visit
OTHER PEDIATRIC VISITS	$20 per visit	$15 per visit
INPATIENT HOSPITAL	No charge	10% per admission
AMBULANCE	No charge	10% per trip
EMERGENCY ROOM	$50 per visit (waived if admitted)	10% per visit
OUTPATIENT SURGERY	$20 per procedure	10% per procedure
X-RAY	No charge	$50 (MRI/CT/PET Scans) $10 Outpatient & preventive $0 Miscellaneous imaging services
LAB	No charge	$10 Outpatient & preventive $0 Miscellaneous laboratory services
PHYSICAL, OCCUPATIONAL, SPEECH THERAPY	$20 per visit	$15 per visit
DURABLE MEDICAL EQUIPMENT	No charge	10% per item
HOME HEALTH CARE	No charge (up to 100 visits per calendar year)	No charge (up to 100 visits per calendar year)
HEARING AIDS	Plan pays: $2,500 allowance per device. One device per ear every 36 months.	Plan pays: $1,000 allowance per device. One device per ear every 36 months.
PRESCRIPTION DRUGS	$10 generic / $30 brand (per 100-day supply)	Basic Coverage Generic: $10 per prescription (up to a 30 day supply) $20 per prescription (31 to 60 day supply) $30 per prescription (61 to 100 day supply) Basic Coverage Brand $20 per prescription (up to a 30 day supply) $40 per prescription (31 to 60 day supply) $60 per prescription (61 to 100 day supply) Mail Order Incentive Generic $10 per prescription (up to a 30 day supply) $20 per prescription (31 to 100 day supply) Mail Order Incentive Brand $20 per prescription (up to a 30 day supply) $40 per prescription (31 to 100 day supply)

NOTE: All copayments, except those for prescription drugs and non-AB88 mental health services apply to the annual out-of-pocket limit.

	CURRENT KAISER PLAN	NEW KAISER PLAN EFFECTIVE 1/1/09
YOUR COPAYMENTS:		
MENTAL HEALTH TNPATIENT TIENTYMENUTPATIENT	No charge (up to 45 days per calendar year) $20 individual/$10 group (up to 20 visits combined per calendar year)	10% per admission (up to 30 days per calendar year) $15 individual/$7 group (up to 30 visits per calendar year)
	Day and visit limits do not apply to severe mental illnesses or serious emotional disturbances of children (AB88)	
CHEMICAL DEPENDENCY NProvided by United	Provided by United Behavioral Health	Provided by United Behavioral Health

NOTE: All copayments, except those for prescription drugs and non-AB88 mental health services apply to the annual out-of-pocket limit.

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