HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI)

Carpenters Health and Welfare Trust Fund for California: Notice of Privacy Practices

Esta noticia es disponible en espanol si usted lo suplica. Por favor contacte el Funcionario de Privacidad (510-639-4301).

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In this notice, the name "Carpenters Health and Welfare Fund" and the terms "we", "us", and "our" encompass not only this health plan itself but also Business Associates acting on behalf of the plan or providing services to the plan. These Business Associates may include a third party administrator, a pharmacy benefits manager, and professionals such as attorneys, auditors, and consultants. It does not include the Board of Trustees, the Plan Sponsor, which will be specified where appropriate.

DUTIES OF CARPENTERS HEALTH AND WELFARE FUND

We are required by law to maintain the privacy of your health information. We must provide you with this Notice of our legal duties and privacy practices with respect to your health information, we are required to notify you if there is a breach of your unsecured protected health information, and we are also required to abide by the terms of this Notice, which may be amended from time to time.

We reserve the right to change the terms of this Notice at any time in the future and to make the new provisions effective for all health information that we maintain. We will promptly revise our Notice and distribute it to all Plan Participants whenever we make material changes to our privacy policies and procedures within 60 days of such change. This Notice will also be provided to all new enrollees as required.

HOW CARPENTERS HEALTH AND WELFARE FUND MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

We are permitted by law to use or disclose your "health information" to conduct activities necessary for "payment" and "health care operations" (as those terms are defined in the attached Glossary). These are the main purposes for which we will use or disclose your health information. For each of these purposes we list below examples of these kinds of uses and disclosures. These are only examples and are not intended to be a complete list of all the ways we may use or disclose your health information.

Payment. We may use or disclose health information about you for purposes within the definition of "payment". These include, but are not limited to, the following purposes and example:

- **Determining your eligibility for plan benefits.** For example, we may use information obtained from your employer to determine whether you have satisfied the plan's requirements for active eligibility.

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

Notice of Privacy Practices

- **Obtaining contributions from you or your employer.** For example, we may send your employer a request for payment of contributions on your behalf, and we may send you information about premiums for COBRA continuation coverage.
- **Pre-certifying or pre-authorizing health care services.** For example, we may consider a request from you or your physician to verify coverage for a specific hospital admission or surgical procedure.
- **Determining and fulfilling the plan's responsibility for benefits.** For example, we may review health care claims to determine if specific services that were provided by your physician are covered by the plan.
- **Providing reimbursement for the treatment and services you received from health care providers.** For example, we may send your physician a payment with an explanation of how the amount of the payment was determined.
- **Subrogating health claim benefits for which a third party is liable.** For example, we may exchange information about an accidental injury with your attorney who is pursuing reimbursement from another party.
- **Coordinating benefits with other plans under which you have health coverage.** For example, we may disclose information about your plan benefits to another group health plan in which you participate.
- **Obtaining payment under a contract of reinsurance.** For example, if the total amount of your claims exceeds a certain amount we may disclose information about your claims to our stop-loss insurance carrier.

Health Care Operations. We may use and disclose health information about you for purposes within the definition of "health care operations". These purposes include, but are not limited to:

- **Conducting quality assessment and improvement activities.** For example, a supervisor or quality specialist may review health care claims to determine the accuracy of a processor's work.
- **Case management and care coordination.** For example, a case manager may contact home health agencies to determine their ability to provide the specific services you need.
- **Contacting you regarding treatment alternatives or other benefits and services that may be of interest to you.** For example, a case manager may contact you to give you information about alternative treatments which are neither included nor excluded in the plan's documentation of benefits but which may nevertheless be available in your situation.
- **Contacting health care providers with information about treatment alternatives.** For example, a case manager may contact your physician to discuss moving you from an acute care facility to a more appropriate care setting.
- **Employee training.** For example, training of new claims processors may include processing of claims for health benefits under close supervision.

CARPENTERS HEALTH AND WELFARE
TRUST FUND FOR CALIFORNIA

Notice of Privacy Practices

- **Accreditation, certification, licensing, or credentialing activities.** For example, a company that provides professional services to the plan may disclose your health information to an auditor that is determining or verifying its compliance with standards for professional accreditation.
- **Securing or placing a contract for reinsurance of risk relating to claims for health care.** For example, your demographic information (such as age and sex) may be disclosed to carriers of stop loss insurance to obtain premium quotes.
- **Conducting or arranging for legal and auditing services.** For example, your health information may be disclosed to an auditor who is auditing the accuracy of claim adjudications.
- **Management activities relating to compliance with privacy regulations.** For example, the Privacy Officer may use your health information while investigating a complaint regarding a reported or suspected violation of your privacy.
- **Resolution of internal grievances.** For example, your health information may be used in the process of settling a dispute about whether or not a violation of our privacy policies and procedures actually occurred.

Disclosures to Plan Sponsor (Board of Trustees). In addition to the circumstances and examples described above, there are three types of health information about you that we may disclose to the Board of Trustees. The disclosures described below are included within the definitions of "payment" or "health care operations".

- We may disclose to the Board of Trustees whether or not you have enrolled in, are participating in, or have disenrolled from this health plan.
- We may provide the Board of Trustees with "summary health information", which includes claims totals without any personal identification except your ZIP code, for these two purposes:
  - To obtain health insurance premium bids from other health plans, or
  - To consider modifying, amending, or terminating the health plan.
- We may disclose your health information to the Board of Trustees for purposes of administering benefits under the plan. These purposes may include, but are not limited to:
  - Reviewing and making determinations regarding an appeal of a denial or reduction of benefits.
  - Evaluating situations involving suspected or actual fraudulent claims.
  - Monitoring benefit claims that may or do involve stop-loss insurance.

CARPENTERS HEALTH AND WELFARE
TRUST FUND FOR CALIFORNIA

Notice of Privacy Practices

Other Uses and Disclosures. The following categories describe other ways that Carpenters Health and Welfare Fund may use and disclose your health information. Each category is illustrated with one or more examples. Not every potential use or disclosure in each category will be listed, and those that are listed may never actually occur.

- **Involvement in Payment**. With your agreement, we may disclose your health information to a relative, friend, or other person designated by you as being involved in payment for your health care. For example, if we are discussing your health benefits with you, and you wish to include your spouse or child in the conversation, we may disclose information to that person during the course of the conversation.
- **Required by Law**. We will disclose your health information when required to do so by Federal, state, or local law. For example, we may disclose your information to a representative of the U.S. Department of Health and Human Services who is conducting a privacy regulations compliance review.
- **Public Health**. As permitted by law, we may disclose your health information as described below:
  - **To an authorized public health authority**, for purposes of preventing or controlling disease, injury or disability;
  - **To a government entity** authorized to receive reports of child abuse or neglect;
  - **To a person under the jurisdiction of the Food and Drug Administration**, for activities related to the quality, safety, or effectiveness of FDA-regulated products.
- **Health Oversight Activities**. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system or compliance with civil rights laws. However, this permission to disclose your health information does not apply to any investigation of you which is directly related to your health care.
- **Judicial and Administrative Proceedings**. We may disclose your health information in the course of any administrative or judicial proceeding:
  - In response to an order of a court or administrative tribunal, or
  - In response to a subpoena, discovery request, or other lawful process.

Specific circumstances may require us to make reasonable efforts to notify you about the request or to obtain a court order protecting your health information.

- **Law Enforcement.** We may disclose your health information to a law enforcement official for various purposes, such as identifying or locating a suspect, fugitive, material witness or missing person.
- **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.
- **Organ and Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, to facilitate such.

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

Notice of Privacy Practices

WHEN CARPENTERS HEALTH AND WELFARE FUND MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. Specifically, most uses and disclosures of your psychotherapy notes (where appropriate), uses and disclosures of your protected health information for marketing purposes, and disclosures that constitute a sale of your protected health information require your written authorization. If you have authorized us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization. However, we will be unable to take back any disclosures we have already made with your permission. Requests to revoke a prior authorization must be submitted in writing to the Privacy Officer at the address shown below.

The Carpenters Health and Welfare Fund will not use or disclose your genetic health information for underwriting purposes. Additionally, you have the right to opt out of receiving any communications concerning fund raising activities in which the Carpenters Health and Welfare Fund may engage.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to restrictions that you request except if the disclosure involves payment or health care operations not required by law and the information pertains solely to a health care item or service that you have paid for out of pocket in full. If you would like to make a request for restrictions, you must submit your request in writing to the Privacy Officer at the address shown below.

Right to Request Confidential Communications. You have the right to ask us to communicate with you using an alternative means or at an alternative location. Requests for confidential communications must be submitted in writing to the Privacy Officer at the address shown below. We are not required to agree to your request unless disclosure of your health information could endanger you.

Right to Inspect and Copy. You have the right to inspect and copy health information about you that may be used to make decisions about your plan benefits. To inspect or copy such information, you must submit your request in writing to the Privacy Officer at the address shown below. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

Right to Request Amendment. If you believe that we possess health information about you that is incorrect or incomplete, you have a right to ask us to change it. To request an amendment of health records, you must make your request in writing to the Privacy Officer at the address shown below. Your request must include a reason for the request. We are not required to change your health information. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial.

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

Notice of Privacy Practices

Right to Accounting of Disclosures. You have the right to receive a list or "accounting" of disclosures of your health information made by us. However, we do not have to account for disclosures that were:

- made to you or were authorized by you, or
- for purposes of payment functions or health care operations.

Requests for an accounting of disclosures must be submitted in writing to the Privacy Officer at the address shown below. Your request should specify a time period within the last six years and may not include dates before April 14, 2003. We will provide one free list per twelve-month period, but we may charge you for additional lists.

Right to Paper Copy. You have a right to receive a paper copy of this Notice of Privacy Practices at any time. To obtain a paper copy of this Notice, send your written request to the Privacy Officer at the address shown below or you can download a copy at www.carpenterfunds.com.

Your Personal Representative

You may exercise your rights to your PHI by designating a personal representative. Your personal representative will be required to produce evidence of the authority to act on your behalf **before** the personal representative will be given access to your PHI or be allowed to take any action for you. Under this Plan, proof of such authority will include a completed, signed and approved form. You may obtain this form by contacting the Privacy Officer or his or her designee at their address listed on the first page of this Notice. The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

This Plan will recognize certain individuals as Personal Representatives **without** you having to complete a Personal Representative form. You may however request that the Plan **not** automatically honor the following individuals as your Personal Representative by completing a form to Revoke a Personal Representative available from the Privacy Officer or their designee.

- For example, the Plan will automatically consider a spouse to be the personal representative of a Plan Participant and vice versa. The recognition of your spouse as your personal representative (and vice versa) is for the use and disclosure of PHI under this Plan and is not intended to expand such designation beyond what is necessary for this Plan to comply with HIPAA privacy regulations. You should also review the Plan's Policy and Procedure regarding Personal Representatives (available from the Privacy Officer) for a more complete description of the circumstances where the Plan will automatically consider an individual to be a personal representative.

YOUR HEALTH INFORMATION PRIVACY RIGHTS

If you would like to obtain a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact:

HIPAA Privacy Officer
Carpenters Health and Welfare Trust Fund for California
P.O. Box 2280
Oakland, CA 94621-0181

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

Notice of Privacy Practices

Complaints. If you believe that your privacy rights have been violated by Carpenters Health and Welfare Trust Fund for California, or by anyone acting on our behalf, you may file a complaint. Complaints to us must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of the Department of Health and Human Services at:

200 Independence Avenue, SW
Washington, DC 20201

We will not retaliate against you in any way for filing a complaint.

Questions. If you have questions about any part of this Notice or if you want more information about the privacy practices at Carpenters Health and Welfare Fund, please contact the Privacy Officer at the above address.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100 ✧ P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215

August 3, 2018

TO: All Active Plan Participants and their Dependents, including COBRA Beneficiaries (Plans A, B, R, and Flat Rate)

FROM: BOARD OF TRUSTEES
Carpenters Health and Welfare Trust Fund for California

RE: Changes to Disability Claim and Appeal Procedures
Changes to Certain Indemnity Plan Benefits

- **Insulin Pen Products**
- **Hearing Exams**
- **Contact Lenses**
- **Routine Physical Exam**

This Participant Notice will advise you of certain material modifications that have been made to your medical benefits for covered services. This information is important to you and your Dependents. Please take the time to read it carefully.

The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California modified the Plan Rules and Regulations for Active Participants and Dependents as follows:

CLAIMS AND APPEALS PROCEDURES FOR CERTAIN DISABILITY CLAIMS Filed on or after April 1, 2018:

The Department of Labor issued new regulations, which provide disability benefit claimants with greater protections for Disability claims under the Plan's Disability Extension benefit or Supplemental Weekly Disability benefit in limited circumstances. The new regulations apply when you reside in a state that does not provide a State Disability Insurance (SDI) benefit and your Physician provided a statement of your disability but the Plan nonetheless, denied your request for a Disability benefit.

The following is a brief description of each of the requirements that may impact you:

1) ***Right to Review and Respond to New Information before Final Decision on a Review of a Denied Claim:*** You have a right to review and respond, in writing or by presenting testimony, to new evidence and rationales considered, relied upon, or generated by the Plan or at the Plan's direction while an appeal is pending (free of charge). This new evidence and/or rationale will be provided to you automatically, as soon as possible, and sufficiently before the deadline for you to file your notice to appeal. The Fund will allow you a reasonable opportunity to respond to new information by presenting written evidence and testimony. Disability claims will be decided within 45 days.

2) ***Deemed Exhaustion of Claims and Appeals Processes:*** If the Fund makes an error with respect to following the new regulations discussed in this Notice, you may be able to file a lawsuit in court immediately, instead of going through the Fund's normal claims procedures (known legally as "exhausting your administrative remedies"). Your claim is legally deemed as denied by the Fund in that instance. You will not be deemed to have exhausted your administrative remedies, and must therefore go through the Fund's normal procedures if: (a)

the Fund's violation was *de minimis* (minor in nature) and did not cause prejudice or harm to you; (b) the violation was for good cause or due to matters beyond the control of the Fund; and (c) the violation occurred in the context of an ongoing, good faith exchange of information between the Fund and you, the claimant.

3) ***Enhanced Disclosure Requirements for Benefit Denial Notices (Both Adverse Determination and Appeal Denial):*** Disability benefit determinations disability benefit denials notices on appeal require, and will include, the following additional information:

   - A statement that you, the claimant, are entitled to receive access to and copies of all relevant documents upon request and without charge.
   - A discussion of the decision, including the basis for disagreeing with or not following the views of a treating physician or vocational professional, the views of medical or vocational experts obtained by the Fund, or a disability determination by the Social Security Administration.
   - If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination as applied to the claimant's medical circumstances will be provided free of charge upon request.
   - The internal rules, guidelines, protocols, standards or other similar criteria the Fund relied on in denying the claim, or a statement that none exist.

   In addition, disability benefit denial on appeal notices require a description of any applicable contractual limitation periods and their expiration dates, in addition to the description of the claimant's right to bring an action under ERISA Section 502(a).

4) ***Notices Must be Provided in Culturally and Linguistically Appropriate Manner:*** The Fund must provide disability denial notices in a culturally and linguistically appropriate manner if your address is in a county where 10% or more of the population residing in that county are literate only in the same non-English language. In such situations, disability denial notices must:

   - Include a prominent one-sentence statement in the relevant non-English language about the availability of language services.
   - Provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language.
   - Provide written notices in the non-English language upon request.

5) ***Conflict of Interest:*** Reviews of disability claims require a process that ensures independence and impartiality among decision-makers. Claim decisions may not be linked to the hiring, compensation, termination, promotion, or other similar matters related to decision-makers (e.g., bonuses based on benefit denials). In addition, the Fund will not contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than on his or her professional qualifications.

6) ***Coverage Rescissions:*** Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (*e.g.,* errors in the application for coverage) must be treated as adverse benefit determinations, thereby triggering the plan's appeals procedures. This would be the case even if the affected participant was not receiving disability benefits at the time of the rescission. Retroactive terminations for non-payment of premiums are not covered by this provision.

INDEMNITY PLAN BENEFIT CHANGES

INSULIN PEN PRODUCTS

Beginning September 1, 2018, the Fund will no longer require preauthorization for insulin pen products. Medically necessary formulary insulin pen products will be covered by the Plan the same as any other covered outpatient prescription drug, subject to applicable outpatient drug copayments and all other applicable Plan provisions.

HEARING EXAMS

Effective January 1, 2018, the Fund will cover hearing exams when ordered by a Physician. Hearing exams will be paid by the Plan at 90% (Plan A and R) or 80% (Plan B or Flat Rate), following satisfaction of the calendar year Deductible for Contract Providers. The Plan will pay 70% (Plan A and R) or 60% (Plan B or Flat Rate) of Allowed Charges, following satisfaction of the calendar year Deductible for Non-Contract Providers. Hearing exam cost-sharing, when applicable, will apply to the Coinsurance Maximum.

To be eligible for coverage, the hearing exam must be medically necessary and performed by a Physician or healthcare practitioner with a master's or doctoral degree in audiology.

The Plan's coverage of hearing aids is otherwise unchanged, and continues to be limited to a maximum payment of $800 per ear in any 3-year period for the covered costs of hearing aids, repairs and servicing combined.

CONTACT LENSES

Beginning September 1, 2018, the Fund will increase the benefit for contact lenses and pay up to a $130 retail allowance for elective contact lenses and fitting and evaluation exam combined. This benefit will continue to be limited to once every 12 months, and is in lieu of any benefit for eye glasses (frames and lenses), and subject to any other applicable Plan provisions. As a reminder, when contact lenses are obtained, you will not be eligible for regular spectacle lenses again for 12 months and frames for 24 months.

ROUTINE PHYSICAL EXAM BENEFIT

Effective August 1, 2017, the Fund covers routine physical examinations for Dependent children of any age. This benefit will continue to be limited to one physical exam in any 12-month period, and subject to normal plan benefits including Deductible and Coinsurance.

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Because this Plan is a "grandfathered health plan," we are required by law to provide this notice to you:

Grandfathered Health Plan: The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California believes the Indemnity Medical 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 preventative 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 or the 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 keep this notice with your benefit booklet. If you have any questions, please contact Benefit Services at the Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to benefitservices@carpenterfunds.com. Forms and information can be found on our website at www.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.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100 ✧ P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215

October 26, 2018

To: **All Active Plan Participants and their Dependents, including COBRA Beneficiaries (Plans A, B, R and Flat Rate)**

From: **BOARD OF TRUSTEES**
Carpenters Health and Welfare Trust Fund for California

Re: **Benefit Changes**
- **Qualification of Domestic Partner and**
- **Indemnity Plan Nutritional Counseling Benefit**

This Participant Notice will advise you of certain material modifications that have been made to your medical benefits for covered services. This information is important to you and your Dependents. Please take the time to read it carefully.

The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California modified the Plan Rules and Regulations for Active Participants and Dependents as follows:

DOMESTIC PARTNER

Effective January 1, 2019, the definition of a Domestic Partner will mean all of the following qualifications have been met:

- A person who you, the Participant, have registered with as a Domestic Partner at any state or local government agency authorized to perform such registrations, and
- A person who you have submitted the required Application and paid the taxes on the imputed income attributable to Domestic Partner benefits.

Please Note:

≠ Domestic Partners enrolled in the Plan prior to January 1, 2019 must also provide proof of registration with a state or local government agency for eligibility to continue on January 1, 2019.

≠ Eligibility for a Domestic Partner shall begin on the first day of the second month after an Application and registration information is verified by the Administrative Office.

≠ Any previous Domestic Partner on the Plan must have been terminated at least 6 months prior to enrolling a subsequent Domestic Partner.

NUTRITIONAL COUNSELING

The Indemnity Medical Plan generally excludes nutritional counseling except when provided as part of a diabetes instruction program. **Effective September 1, 2018,** nutritional counseling will also be covered under the Indemnity Medical Plan when services are medically necessary for the treatment of an individual diagnosed with a mental health condition, such as an eating disorder. Services will be subject to the Plan's calendar year deductible and applicable coinsurance.

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Because this Plan is a "grandfathered health plan," we are required by law to provide this notice to you:

Grandfathered Health Plan: The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California believes the Indemnity Medical 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 preventative 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 or the 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 keep this notice with your benefit booklet. If you have any questions, please contact Benefit Services at the Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to benefitservices@carpenterfunds.com. Forms and information can be found on our website at www.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.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan.

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA
265 Hegenberger Road, Suite 100
Oakland, California 94621-1480
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com

November 29, 2019

To: **All Active and Non-Medicare Retired Participants and their Dependents, including COBRA Beneficiaries**

From: **BOARD OF TRUSTEES**

Re: **Changes to Plan Benefits Effective January 1, 2020**

- **Outpatient Surgical Procedures**
- **Routine OB-GYN Exam Benefit**
- **Vision Benefit**
- **Breast Pump**
- **Stem Cell Treatment**
- **Providers under investigation for Fraud**
- **Health Dynamics and Trestle Tree Termination**

This Participant Notice will advise you of certain material modifications that have been made to your medical benefits for covered services. **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

The Board of Trustees modified the Plan Rules and Regulations as follows, effective January 1, 2020:

1. CHANGES TO PLAN BENEFITS FOR CERTAIN SURGERIES AT AN OUTPATIENT HOSPITAL:

The Plan currently has a payment limit for use of an outpatient hospital facility for an arthroscopy, cataract surgery, colonoscopy or endoscopy. These surgical procedures performed at an Anthem PPO Contracted ambulatory surgical center have no Plan payment limit and the Plan pays benefits subject to normal Plan Rules, deductible, coinsurance, and coinsurance maximums.

Beginning January 1, 2020, more surgical procedures will be added to the list of outpatient hospital payment limits for surgeries performed at an outpatient hospital instead of a PPO Contracted ambulatory surgical center.

Below please find an updated list of the surgeries and the associated Maximum Payment Limit that will apply when provided in an Outpatient Hospital Setting.

The Plan is also adding a precertification requirement for the below outpatient surgery procedures. Please have your healthcare practitioner contact Anthem at (800) 274-7767 so you can be directed to an Anthem PPO Contracted ambulatory surgical center. Failure to comply with the Plan's requirements for precertification may result in an increase of your out-of-pocket costs.

Surgery	Maximum Payment Limit per Procedure
At an Outpatient Hospital (instead of a PPO Contracted Ambulatory Surgical Center)	
Arthroscopy	$6,000
Cataract Surgery	$2,000
Colonoscopy	$1,500
Sigmoidoscopy	$1,000
Upper Gastrointestinal Endoscopy	$1,500
Upper Gastrointestinal Endoscopy with Biopsy	$2,000
Esophagoscopy	$2,000
Hysteroscopy Uterine Tissue Sample (with Biopsy, with or without Dilation and Curettage)	$3,500
All other Endoscopies	$1,000
Laparoscopic Gall Bladder Removal	$5,000
Nasal/Sinus - Submucous Resection Inferior Turbinate	$3,000
Nasal/Sinus - Corrective Surgery - Septoplasty	$3,500
Tonsillectomy and/or Adenoidectomy	$3,000
Lithotripsy – Fragmenting of Kidney Stones	$7,000
Hernia Inguinal Repair (Over age 5, Non-Laparoscopic)	$4,000
Laparoscopic Inguinal Hernia	$5,500

If you use an Outpatient Hospital for any of the above surgeries, you will be responsible for paying any amount over the maximum. Amounts denied as over the maximum for a procedure will not accumulate toward your Coinsurance Maximum.

If you are scheduled for one of the above surgeries, **please make sure your surgery is performed at a PPO Contracted ambulatory surgical center.** This will save money for both you and the Fund.

2. NEW ANNUAL ROUTINE OB-GYN EXAM BENEFIT:

At this time, the Fund allows a routine physical examination for a Participant and Spouse once within a 12-month period. Women are able to use this benefit for either their routine OB-GYN visit or at another physician for a physical exam. Beginning for services on or after January 1, 2020, the Fund will allow both one routine OB-GYN examination within a 12-month period in addition to one routine physical exam within a 12-month period (payable at normal Plan benefits). Coverage includes any x-rays and laboratory tests provided in connection with the OB-GYN exam and physical examination, including a pap smear.

3. CHANGES TO VISION BENEFIT ALLOWANCES:

The following allowances for covered vision services with a VSP provider have been increased for services on or after January 1, 2020.

- The frame allowance is increasing to $175 at VSP doctors and retail chains, and to $95 at Costco Optical Center, limited to once every 24 months.

- The elective contact lens allowance is increasing to $155 for contact lenses and fitting and evaluation exam, limited to once every 12 months in lieu of lenses and frames.

4. BREAST PUMP:

The Plan has added a benefit for rental or purchase of a breast pump for females who are breastfeeding. Either a manual or an electric breast pump is covered, payable at normal Plan benefits up to a maximum benefit payment of $75 per calendar year beginning January 1, 2020.

5. STEM CELL TREATMENT:

Stem cell treatments that have not been approved by the Federal Food and Drug Administration (FDA) are excluded by the Plan.

6. PROVIDERS UNDER INVESTIGATION FOR FRAUD:

Medical providers that have been determined to have engaged in fraudulent activity, following an investigation by the Plan's Fraud, Waste and Abuse vendor are excluded from any Plan benefits.

7. HEALTH DYNAMICS AND TRESTLE TREE TERMINATION:

The Plan has terminated its contract with Health Dynamics who provided physical exams, screenings, and health coaching services. The Plan also terminated its contract with Trestle Tree who provided health coaching related to wellness and disease management.

Reminder: Services provided by a Non-Contract provider who does not complete enrollment in the Medicare program are limited or not payable. The Plan limits Medically Necessary *outpatient* services from Non-Contract Providers who are not registered with the Centers for Medicare & Medicaid Services (CMS) to **a maximum allowable charge of $100 per appointment**, subject to the non-PPO deductible and coinsurance. Benefits paid *for inpatient* services from a Non-Contract Provider is based on a percentage of that provider's CMS registered fee; there will be no benefits available for inpatient services from a Non-Contract Provider who is not registered with CMS.

* * * * *

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Grandfathered Health Plan: The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California believes the Indemnity medical plan is "grandfathered health plans" 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 plan, for example, the requirement for the provision of preventative 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 and do not apply to a grandfathered health plan and what might cause a plans to change from grandfathered health plan status can be directed to the Plan Administrator or the 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 keep this notice with your benefit booklet. If you have any questions, please contact Benefit Services at the Fund Office at benefitservices@carpenterfunds.com, (510) 633-0333 or toll free at (888) 547-2054. Find forms and information on our website, www.carpenterfunds.com.

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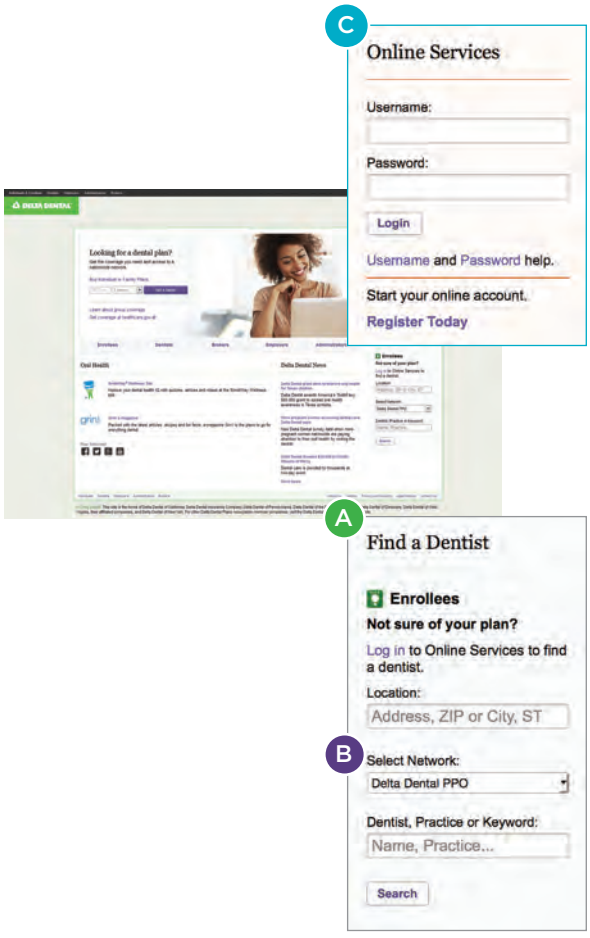
DELTA DENTAL®

Delta Dental PPO℠
Delta Dental Premier®
DeltaCare® USA

Find a Network Dentist

It's easy to look for a Delta Dental dentist in your area. Whether you're on a laptop, desktop computer, tablet or smartphone, we've got you covered.



WEBSITE:

For computer or tablet

Go to **deltadentalins.com**.

A. **Search for a dentist.** Look for the **Find a Dentist** tool on the right. Enter a location (address, ZIP code or city and state), and select your plan from the drop-down menu. For a more targeted search, you can enter the name of your dentist or dental office. Click Search. **Optional:** Filter your search results by categories such as specialty, language, gender, extended office hours and accessibility.

B. **Current dentist.** Want to see if your current dentist is in-network? Just search by the name of your dentist or dental office and location, and choose "All of the above" for network. The network(s) will be listed when you click on your dentist or dental office.

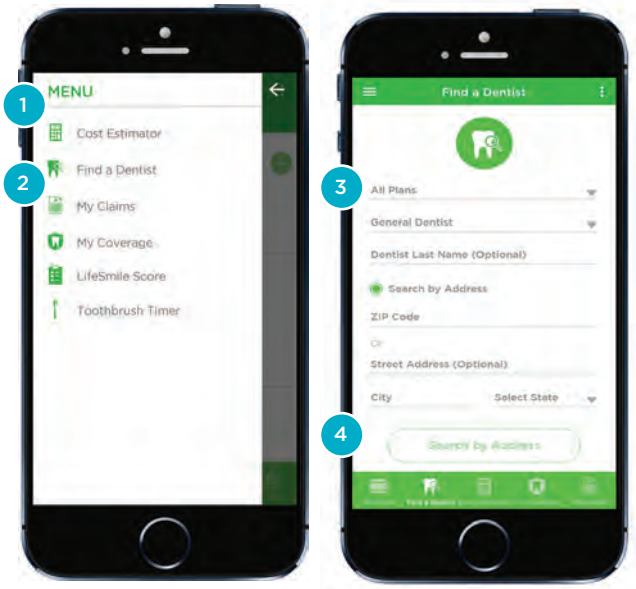
C. **Find out your network.** Don't know which network you're in? Log in to Online Services before searching. You can register for an account as soon as your coverage begins.

MOBILE APP[1]:

For smartphone or tablet

First, install the Delta Dental app from Google Play or the App Store.

1. Click on the menu in the top-left corner.
2. Select **Find a Dentist.**
3. Select your plan and the type of dentist you are searching for.
4. Click on **Search by Current Location** or **Search by Address.**



MOBILE-OPTIMIZED SITE[1]:

For smartphone

1. Go to **deltadentalins.com**.
2. Click on **Visit Mobile Site.**
3. Click on **Find a Dentist.**
4. Enter your location, select a distance and plan (network) from the drop-down menu, optionally filter your search by dentist or specialty and click **Search.**

[1] Some features available to PPO and Premier enrollees only.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100
Oakland, California 94621-1480
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215

April 3, 2020

TO: All Active Plan Participants, Non-Medicare Retirees and their Dependents including COBRA Beneficiaries

FROM: BOARD OF TRUSTEES
Carpenters Health and Welfare Trust Fund for California

RE: BENEFIT CHANGES – INDEMNITY PLAN
Online Telehealth Medical Visits
COVID-19 Laboratory Tests
Prescription Drug Benefits

This Notice will advise you of certain material modifications that were made to your medical and prescription benefits.

It is the intent of the Plan to comply with federally mandated benefit requirements. Unless superseded by law with mandatory additional benefits, **effective March 1, 2020, the Health and Welfare Plan will provide 100% coverage of the PPO Allowed Amount for COVID-19 laboratory testing by a Contract Provider as well as 100% coverage for telehealth medical visits through LiveHealth Online.** COVID-19 testing and LiveHealth Online services will not be subject to the Plan's calendar year deductible.

Online Telehealth Medical Visits

LiveHealth Online allows you to access private and secure video visits with a board-certified doctor 24 hours a day using your smartphone, tablet or computer that has a webcam. Physicians available through LiveHealth Online can evaluate your symptoms, help you understand your condition, including the possibility of contracting the COVID-19 virus, all the while minimizing the risk of exposure of disease to yourself and others because your visit is in the comfort of your own home. In addition to the LiveHealth Online visit being available at no cost, no appointment is necessary and wait times are nominal.

To get started, go to livehealthonline.com and sign up by:

1. Choose **Sign Up** to create your LiveHealth Online account. Enter your name, email address, date of birth and create a secure password.
2. Read and agree to the *Terms of Use*.
3. Choose your location in the drop-down box of states.
4. Enter your birth date and choose your gender.
5. For the question "Do you have insurance?", select **Yes**. Be sure to have your medical identification card available to complete the insurance information. If you choose **No**, you can enter your insurance information later.
6. For **Health Plan**, in the drop-down box, select **Anthem**.
7. For the **Subscriber ID**, enter your identification number, which is found on your medical identification card. Select **Yes** if you are the Plan Participant or **No** if you are a Dependent

of the Participant.

8. Select the green **Finish** button.

For questions about how to use LiveHealth Online, call toll free (888) 548-3432 or email help@livehealthonline.com.

COVID-19 Laboratory Tests

The Plan will provide 100% coverage of the PPO Allowed Amount for COVID-19 laboratory testing by a Contract Provider. COVID-19 laboratory testing by a non-Contract Provider is payable at 100% of the average Contract Provider rate, not subject to the Plan's calendar year deductible. You will be responsible for any charge in excess of the Plan's payment if you use a non-Contract Provider. When possible, the Plan encourages you to use a Contract Provider to prevent an out-of-pocket cost to you for COVID-19 laboratory testing.

Prescription Drug Benefits

The Health and Welfare Plan contracts with Express Scripts, a prescription benefit management (PBM) firm, to administer the Prescription Drug benefits for our Participants. Express Scripts has implemented a number of best practices to help manage the safety and efficiency of the prescription drug program.

On or after March 1, 2020, there will be no benefit payment for the following prescriptions:

- A medication excluded under the PBM's Pharmacy and Therapeutics Committee or United Brotherhood of Carpenter's Clinical Advisory Committee,
- A drug not approved through the step therapy program,
- A drug requiring pre-authorization when pre-authorization is not obtained,
- A medication that has not been approved by the Food and Drug Administration for the indication prescribed unless such use has been reviewed and approved by the PBM's Pharmacy and Therapeutics Committee or United Brotherhood of Carpenter's Clinical Advisory Committee,
- A medication that does not satisfy Express Scripts' clinical guidelines for safety, or cost saving protocols.

If you are taking a medication not covered by the Plan, we recommend that you talk to your doctor to discuss medication options that the Plan does cover. If you have any questions regarding your prescription drug coverage, including questions regarding medications covered under the program, please refer to Express Scripts at (800) 939-7093 or www.express-scripts.com.

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health plan status can be directed to the Plan Administrator or the 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 keep this notice with your benefit booklet. If you have any questions, please contact Benefit Services at the Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to benefitservices@carpenterfunds.com. Forms and information can be found on our website at www.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.

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CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215

October 3, 2020

TO: **All Active and non-Medicare Eligible Retired Plan Participants and their Dependents, including COBRA Beneficiaries**

FROM: **BOARD OF TRUSTEES**
Carpenters Health and Welfare Trust Fund for California

RE: **Changes to Outpatient Hospital Indemnity Plan Benefits**
- **Hip Replacement Surgery**
- **Knee Replacement Surgery**

This Participant Notice will advise you of a material modification that has been made to your medical benefits for hospital benefits payable for services in connection with a hip or knee replacement surgery. This information is important to you and your Dependents. Please take the time to read it carefully.

Effective October 1, 2020, in order to manage the cost variance for hip and knee replacement surgeries, payment will be limited to a $30,000 maximum for single hip joint replacement or single knee joint replacement surgery for both inpatient and outpatient facility costs. The maximum does not include professional fees such as anesthesia or surgeon fees, which will be paid pursuant to the applicable Plan's Rules and Regulations.

The Board of Trustees and Anthem Blue Cross have identified 50 facilities throughout California where these surgeries can be performed with little to no out-of-pocket costs beyond the Plan's deductible and coinsurance. See the attached list of approved Value Based facilities. You still have the same access to providers but will save money when you use a recommended facility.

* * * * *

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to benefitservices@carpenterfunds.com. Forms and information can be found on our website at www.carpenterfunds.com.

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Value-based purchasing

Hip and knee joint replacement

Value-based purchasing design (VBPD)

Carpenters Health and Welfare Trust Fund for California and Anthem Blue Cross (Anthem) are working together to design a hip and knee joint replacement program. If you will be scheduling a hip or knee joint replacement, this program is for you. It has been designed to keep your overall out-of-pocket costs down, while limiting the overall increase in medical costs.

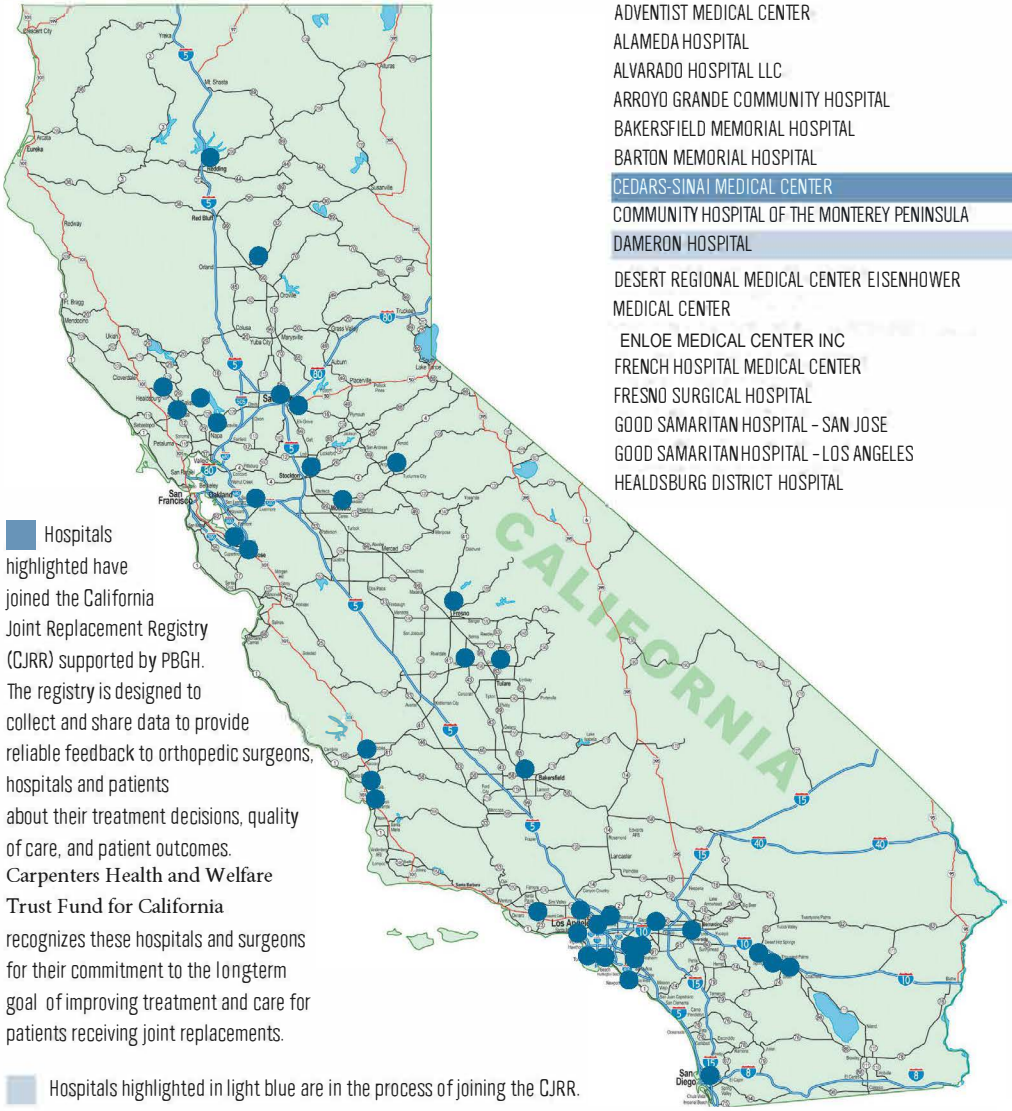
This program limits payment to $30,000 maximum for single hip joint replacement or single knee joint replacement surgeries. **Carpenters Health and Welfare Trust Fund for California** and Anthem have identified 53 facilities throughout California where you can have these surgeries done with little to no out-of-pocket costs beyond the plan's deductible and coinsurance.

If you have a single hip or single knee joint replacement at a facility that isn't on the list below, you'll be responsible for any charges above $30,000. You'll also be responsible for any deductible and coinsurance.

As a Participating Provider Organization plan member, you have the option to choose any facility, but if you get care from one of the 53 facilities listed below, you can lower your out-of-pocket costs.

Please refer to your *Evidence of Coverage* booklet for more info.

Value Based Sites of Care for designated Hospitals



ADVENTIST MEDICAL CENTER
ALAMEDA HOSPITAL
ALVARADO HOSPITAL LLC
ARROYO GRANDE COMMUNITY HOSPITAL
BAKERSFIELD MEMORIAL HOSPITAL
BARTON MEMORIAL HOSPITAL
CEDARS-SINAI MEDICAL CENTER
COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA
DAMERON HOSPITAL
DESERT REGIONAL MEDICAL CENTER EISENHOWER MEDICAL CENTER
ENLOE MEDICAL CENTER INC
FRENCH HOSPITAL MEDICAL CENTER
FRESNO SURGICAL HOSPITAL
GOOD SAMARITAN HOSPITAL - SAN JOSE
GOOD SAMARITAN HOSPITAL - LOS ANGELES
HEALDSBURG DISTRICT HOSPITAL
HOAG ORTHOPEDIC INSTITUTE
HUNTINGTON MEMORIAL HOSPITAL
JOHN F KENNEDY MEMORIAL HOSPITAL
JOHN MUIR MEDICAL CENTER - CONCORD CAMPUS JOHN MUIR MEDICAL CENTER - WALNUT CREEK CAMPUS KAWEAH DELTA MEDICAL CENTER
LOMA LINDA UNIVERSITY MEDICAL CENTER
LONG BEACH MEMORIAL MEDICAL CENTER
MERCY MEDICAL CENTER - REDDING
METHODIST HOSPITAL OF SACRAMENTO (TERMED 7/15/2021)
NATIVIDAD MEDICAL CENTER
O'CONNOR HOSPITAL
PLACENTIA LINDA HOSPITAL
QUEEN OF THE VALLEY MEDICAL CENTER
SAN ANTONIO COMMUNITY HOSPITAL
SAN JOAQUIN COMMUNITY HOSPITAL
SANTA MONICA UCLA MEDICAL CENTER
SANTA ROSA MEMORIAL HOSPITAL
SIERRA VISTA REGIONAL MEDICAL CENTER
SONORA REGIONAL MEDICAL CENTER
ST AGNES MEDICAL CENTER
ST HELENA HOSPITAL
ST JOHN'S HOSPITAL AND HEALTH CENTER
ST JOSEPH HOSPITAL - ORANGE
ST JUDE MEDICAL CENTER
ST MARYS MEDICAL CENTER (TERMED 7/15/2021)
ST VINCENT MEDICAL CENTER
STANISLAUS SURGICAL HOSPITAL
THOUSAND OAKS SURGICAL HOSPITAL
TORRANCE MEMORIAL MEDICAL CENTER
TWIN CITIES COMMUNITY HOSPITAL INC
UCSD MEDICAL CENTER
VALLEY PRESBYTERIAN HOSPITAL

Hospitals highlighted have joined the California Joint Replacement Registry (CJRR) supported by PBGH. The registry is designed to collect and share data to provide reliable feedback to orthopedic surgeons, hospitals and patients about their treatment decisions, quality of care, and patient outcomes. **Carpenters Health and Welfare Trust Fund for California** recognizes these hospitals and surgeons for their commitment to the longterm goal of improving treatment and care for patients receiving joint replacements.

Hospitals highlighted in light blue are in the process of joining the CJRR.

For more information about the CJRR, please visit caljrr.org.

To learn more, please visit anthem.com/ca.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100
Oakland, California 94621-1480
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215

November 30, 2020

TO: All Active and Non-Medicare Eligible Retired Plan Participants and their Dependents, including COBRA Beneficiaries

FROM: BOARD OF TRUSTEES
Carpenters Health and Welfare Trust Fund for California

RE: Indemnity Plan Benefit Change for Flu Vaccines

This Participant Notice will advise you of a material modification that has been made to your medical benefits for services in connection with flu vaccines. This information is important to you and your Dependents. Please take the time to read it carefully.

Flu Vaccines

Effective September 1, 2020, the Plan will provide 100% coverage of the PPO Allowed Amount for flu vaccinations, up to a maximum payment of $30 per vaccine. Should you receive a flu vaccination by a Non-Contract Provider, the Plan will provide 100% coverage of the charged amount, up to a maximum payment of $30. Additionally, the flu vaccines are not subject to the calendar year deductible.

The Trustees designed this Indemnity benefit so that you have broader access to flu vaccines, for example, you can get your vaccine through your local pharmacy. Should you choose to receive a flu vaccine at your pharmacy, you may submit your claim for reimbursement to the Fund Office by providing the following information: 1) A copy of your receipt that includes the name of the person receiving the vaccine, 2) The date the vaccine was administered and 3) The amount paid. Also, please include a copy of your medical card.

Send Claims to:
Carpenter Funds Administrative Office
Attention: Claims Department
265 Hegenberger Rd., Suite 100
Oakland, CA 94621

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CARPENTERS HEALTH AND WELFARE
TRUST FUND FOR CALIFORNIA **carpenterfunds.com**

265 Hegenberger Road, Suite 100
Oakland, California 94621-1480
Toll-Free: 1 (888) 547-2054
Phone: (510) 633-0333

April 9, 2021

TO: All Plan Participants and their Dependents, including COBRA Beneficiaries

FROM: BOARD OF TRUSTEES
Carpenters Health and Welfare Trust Fund for California

RE: Kaiser and Indemnity Plan Benefit Changes
- **Deadline Extensions**
- ***headversity***
- **COBRA Subsidy**

Indemnity Plan Benefit Changes
- **Vaccines**
- **COVID-19 Testing**
- **Telehealth**

This Participant Notice will advise you of material modifications that have been made to your Health and Welfare Plan benefits. This information is important to you and your Dependents. Please take the time to read it carefully.

As of the date of this notice the COVID-19 Public Health Emergency is effective until April 21, 2021, however that date is expected to be extended. **Once the Public Health Emergency is lifted, some of the Plan's limitations for using Non-Covered Providers will be reinstated as outlined in this notice. It's important to note that the National Emergency declared by the U.S. President is different than the Public Health Emergency.**

KAISER AND INDEMNITY PLAN BENEFIT CHANGES

Duration of Extensions for Certain Special Enrollment, COBRA and Claims and Appeals Deadlines

In 2020, we informed you that the Plan would disregard the filing limit periods from March 1, 2020, through the end of the National Emergency plus 60 days. The National Emergency effects issues concerning COBRA, special enrollment, claims and appeals deadlines:

- The period to request special enrollment,
- The 60-day election period for COBRA Continuation Coverage,
- The date for making COBRA Continuation Coverage premium payments,
- The date for individuals to notify the Plan of a qualifying event or the determination of disability,
- The date within which individuals may file a benefit claim under the Plan's claims procedures, and
- The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedures.

Recent guidance from the Department of Labor clarified the duration of these deadline extensions, which applies on a case-by-case basis. Specifically, your deadline is **the earlier of:**

- One year from the date you were first eligible for relief (i.e., one year from your original deadline); or
- 60 days after the announced end of the National Emergency Concerning COVID-19.

PLEASE NOTE: Under no circumstances will a deadline extension last longer than one year. To ensure you receive the benefits you are entitled to, we encourage you to provide your election notice or payment by the original deadline. See examples on the following page.

For example, if your original deadline for electing COBRA Continuation Coverage was April 1, 2020, you will have until April 1, 2021, to make that election. If your original deadline for electing COBRA Continuation Coverage was September 1, 2020, you will have until September 1, 2021, to make that election or 60 days after the National Emergency concerning COVID-19 ends, if that date occurs before September 1, 2021.

Please contact the Fund Office if you have questions about how the deadline extensions apply to your individual circumstances.

headversity – New Benefit

The Board of Trustees has also implemented a new resource available to Participants and their Dependents beginning February 1, 2021. The *headversity* program trains and prepares individuals to better manage mental health and mental performance challenges, thereby helping them get ahead of possible adversity in the future. The program focuses on six resilience skills: self-expertise, mindfulness, mental fitness, mental health, hardiness, and energy management.

headversity is an App that Participants and Dependents can use to access resources and training on building resilience. The *headversity* App can be accessed through your smartphone's App store.

headversity

Use Invite Code
NCCARP
To Start Your Training Today

ARPA COBRA Subsidy

Congress passed the American Rescue Plan Act (ARPA) on March 17, 2021. ARPA includes many COVID-19 related relief measures including a subsidy for Health and Welfare coverage under COBRA which grants $0 cost Plan coverage to Participants and Dependents who have lost coverage because of an involuntary reduction of work hours between September, 2019 and July, 2021.

If you had, or later have, an involuntarily loss of work in Covered employment and you have no other employer sponsored health coverage or Medicare, ARPA will pay 100% of the cost of COBRA coverage beginning April 1, 2021 through September 30, 2021. The subsidy pays medical, dental, vision and prescription coverage for most qualified recipients. Furthermore, your coverage does not have to be continuous. For example, you may enroll in the COBRA ARPA subsidy effective April 1, 2021 even though your 18-month COBRA option started many months earlier and you did not elect COBRA coverage for the months prior to April 1, 2021.

INDEMNITY PLAN BENEFIT CHANGES

Changes to Vaccine Coverage, Including Coverage COVID-19 Vaccines

Effective January 1, 2021, The Board of Trustees implemented a comprehensive vaccine coverage program. Immunizations, including the COVID-19 and flu vaccines, are covered under both the Plan's medical and pharmacy benefits with a $0 copayment and no deductible when received from a PPO Contract Medical Provider or Contract Pharmacy. The Board of Trustees rescinded the flu vaccine Plan maximum payment of $30 under the medical benefit.

After the Public Health Emergency ends, the Plan will continue to cover COVID-19 vaccines at 100% with no deductible when received from a Contract Provider, however; COVID-19 vaccines will no longer be covered in full when received from Non-Contract Providers. A list of immunizations covered under the pharmacy program, which includes most preventive vaccinations, is available from Express Scripts.

Clarification of COVID-19 Testing Benefits

Last April, we informed you that the Plan would cover COVID-19 laboratory tests at 100% when received from either Contract Providers or Non-Contract Providers. To clarify, the 100% coverage benefit includes: test administration, items and services given during office visit, urgent care, telehealth and emergency room visits, to the extent they relate to the evaluation or furnishing of the test.

During the Public Health Emergency, Non-Contract Providers will be paid the cash price listed on their public website or, if lower, the negotiated price.

See the Table on page 2 (Benefit Snapshot) for a comparison of Immunization and COVID-19 testing benefit limits for "*During the Public Health Emergency" vs. "After the Public Health Emergency"*.

<table>
<tr><th colspan="3">Benefit Snapshot</th></tr>
<tr><th>Service</th><th>During Public Health Emergency</th><th>After Public Health Emergency
(Restrictions Lifted)</th></tr>
<tr><td>COVID-19 Vaccines</td><td rowspan="3">Effective 1/1/2021:
Participant Cost: $0
Receive immunizations from any Medical Provider or Contract Pharmacy</td><td rowspan="3">Participant Cost: $0
Must use a PPO Contract Provider or Express Scripts Contract Pharmacy</td></tr>
<tr><td>Flu Vaccines</td></tr>
<tr><td>Other Immunizations</td></tr>
<tr><td>COVID-19 Laboratory Tests</td><td>Effective 3/1/2020:
Participant Cost: $0
Tests administered by any Medical Provider, plus items and services given during office, urgent care, telehealth and emergency room visits in relation to evaluation or furnishing of the test.</td><td>Participant Cost: Based on the existing Plan Limitations.
Depending on the location of where the test is administered and all existing Plan limitations regarding payment to Non-Contract Providers will be applied.</td></tr>
<tr><td>Finding a Contract Provider</td><td colspan="2">Medical Providers
Anthem (800) 810-2583 or www.anthem.com

Contract Pharmacy for Immunizations
Express Scripts (800) 939-7093 or www.express-scripts.com</td></tr>
</table>

Clarification of Online Telehealth Visit Benefit

Last April, we informed you that the Plan will cover LiveHealth Online visits at 100% up to a maximum payment of $59. To clarify, online telehealth visits with PPO providers are also covered by the Plan, subject to the Plan's deductible and coinsurance for the duration of the Public Health Emergency, which is currently through April 21, 2021, unless extended. At the conclusion of the Public Health Emergency, the issue of online telehealth visits will be revisited by the Board of Trustees.

Because this Plan is a “grandfathered health plan,” we are required by law to provide this notice to you:

> **Grandfathered Health Plan:** The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California believes the Indemnity Medical 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 preventative 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 or the 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 keep this notice with your benefit booklet. If you have any questions, please contact Benefit Services at the Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to benefitservices@carpenterfunds.com. Forms and information can be found on our website at www.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.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan.

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA
265 Hegenberger Road, Suite 100
P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com

July 16, 2021

To: All Active Participants and their Beneficiaries – Plan B and Flat Rate Plan

From: BOARD OF TRUSTEES
Carpenters Health and Welfare Trust Fund for California

Re: SUMMARY OF BENEFITS AND COVERAGE (SBC) required by the Affordable Care Act (ACA)

As required by law, group health plans like ours are providing plan participants with a Summary of Benefits and Coverage (SBC) as a way to help understand and compare medical benefits. The SBC provides a brief overview of the medical plan benefits provided by the Carpenters Health and Welfare Trust Fund for California. Please share this SBC with your family members who are also covered by the Plan.

Each SBC contains concise medical plan information in plain language about benefits and coverage. This includes what is covered, what you need to pay for various benefits, what is not covered, and where to go for more information or to get answers to questions. Government regulations are very specific about the information that can and cannot be included in each SBC so the Plan is not allowed to customize much of the form or content. The attached SBC includes:

- A health plan comparison tool called "Coverage Examples." These examples illustrate how the medical plan covers care for three common health scenarios: having a baby, diabetes care and care for a fractured bone. These examples show the projected total costs associated with each of these three situations, how much of these costs the Plan covers and how much you, the Participant, need to pay. In these examples, it's important to note that the costs are national averages and do not reflect what the actual services might cost in your area. Plus, the cost for your treatment might also be very different depending on your doctor's approach, whether your doctor is an In-Network PPO Provider or a Non-PPO Provider, your age and any other health issues you may also have. These examples are there to help you compare how different health plans might cover the same condition—not for predicting your own actual costs.
- A link to a "Glossary" of common terms used in describing health benefits, including words such as *"deductible," "co-payment,"* and *"co-insurance."* The glossary is standard and cannot be customized by a Plan.
- Websites and toll-free phone numbers you can contact if you have questions or need assistance with benefits.

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.carpenterfunds.com or call 1-888-547-2054. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.carpenterfunds.com or call 1-888-547-2054 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Contract Provider: $128/individual per calendar year; $256/family per calendar year. Non-Contract Provider: $257/person per calendar year; $514/family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Mental health, chemical dependency (including detox), member assistance program visits, Contract Provider On-line physician visits up to $49 per visit, and outpatient prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	There is no out-of-pocket limit on all types of cost sharing, but there is a $6,445/person ($12,890/family) on the amount of coinsurance that you must pay for covered services in a year.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, hearing examination and hearing aid expenses, penalties for failure to obtain precertification, deductibles, expenses from Non-Contract providers, outpatient retail/mail order prescription drug expenses, amounts over the reference-based pricing allowances and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-888-547-2054 for a list of Contract providers in California. See www.bcbs.com or call 1-800-	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's

Important Questions	Answers	Why This Matters:
	810-2583 for a list of Contract providers outside the state of California.	charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	• Services from Non-Contract providers not registered with CMS are limited to $100/appointment. • Plan pays 100% for physician online visits with a Contract provider.
	Specialist visit	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Preventive care/screening/ Immunization	20% coinsurance	40% coinsurance	• For adults and children, benefits are limited to one routine physical exam in any 12-month period. • For Employee and Spouse only, benefits include one routine Ob-Gyn examination within a 12-month period in addition to the routine physical. Coverage includes any x-rays and laboratory tests provided in connection with the physical examination, including a pap smear. • You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. • Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Professional/physician charges may be billed separately (Services from Non-Contract providers not registered with CMS are limited to $100/appointment). Precertification is required for CT/CTA, MRI, Nuclear Cardiology, Pet Scans and Echocardiography.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or call 1-800-939-7093.	Generic drugs	Retail: $15 copay/fill. Mail order: $26 copay/fill	You pay 100% (unless there are no network pharmacies within 10 miles). Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	• Retail Pharmacy – 30-day supply • Mail Order Pharmacy – 90-day supply • Deductible does not apply to outpatient prescription drugs. • Cost sharing for outpatient prescription drugs **does not count** toward the out-of-pocket limit. • If the cost of the drug is less than the copay, you pay just the drug cost. • Some prescription drugs are subject to preauthorization (to avoid non-payment), or step therapy requirements. • Brand name Proton Pump Inhibitors (PPI) and Cholesterol drugs not covered. • For any new Brand Name Drug approved by the federal FDA, including injectable and infusion drugs, the copay is 50% of the cost of the drug for a minimum of 24 months after the drug has been approved. If the PBM determines that the new FDA-approved drug is a "must not add" drug, the copay will remain at 50% of the cost of the drug. • Mail Order is mandatory if more than 2 prescriptions are filled for maintenance medications.
	Preferred brand drugs (Formulary brand drugs)	Retail: $15 copay/fill + cost difference between generic and brand for multi-source brand. $53 copay/fill for single-source formulary brand. Mail order: $26 copay/fill + cost difference between generic and brand for multi-source brand. $106 copay/fill for single-source formulary brand.		
	Non-preferred brand drugs (Non-formulary brand drugs)	Retail: $80 copay/fill; Mail Order: $133 copay/fill		
	Specialty drugs	Subject to Retail Copays (30-day supply).	Not covered	Specialty drugs are available only from the PBM's Mail Order Pharmacy (except certain emergency drugs may be provided by a retail Participating Pharmacy).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance plus any amounts over $300	For certain outpatient surgeries, the Plan has a maximum benefit payable if services are done at a hospital facility instead of an ambulatory surgery center. To avoid Plan maximums, precertification is required for outpatient surgeries.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	***Medical:*** 20% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 40% coinsurance (20% coinsurance if no choice in hospital due to emergency). ***Mental Health or Substance Abuse:*** No charge	Professional/physician charges may be billed separately. (Services from Non-Contract providers not registered with CMS are limited to $100/appointment).
	Emergency medical transportation	20% coinsurance	20% coinsurance.	Limited to emergency care or medically necessary inter-facility transfer to the nearest hospital, only. Services provided by an Emergency Medical Technician (EMT) without subsequent emergency transport are covered.*See Article 1 of the Plan Document for more information on emergency care.
	Urgent care	***Medical:*** 20% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 40% coinsurance (20% coinsurance if no choice in hospital due to emergency). ***Mental Health or Substance Abuse:*** No charge	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	• Precertification is required. • A maximum of $30,000 is payable for the hospital facility charges associated with a single hip joint or knee joint replacement surgery. • In a Non-Contract Hospital, the plan covers a room with 2 or more beds (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used). • Services from Non-Contract providers not registered with CMS are not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	***Mental Health:*** Office visit: No charge, deductible does not apply. Other outpatient services: 20% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply	40% coinsurance, deductible does not apply.	• Plan pays 100% for physician online visits with a Contract provider. • Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Inpatient services	***Mental Health:*** 20% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply.	40% coinsurance, deductible does not apply.	• Precertification is required. • In a Non-Contract Hospital, the plan covers a room with 2 or more beds (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used) • Services from Non-Contract providers not registered with CMS are not covered.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	• Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). • Services from Non-Contract providers not registered with CMS are limited to $100/appointment
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Precertification is required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. Services from Non-Contract providers not registered with CMS are not covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Rehabilitation services	20% coinsurance	40% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $100/appointment. ***Inpatient:*** Services from Non-Contract providers not registered with CMS are not covered.
	Habilitation services	Not covered	Not covered	You pay 100% for this service, even in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification is recommended. Limited to 70 days per confinement. Services from Non-Contract providers not registered with CMS are not covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental covered up to reasonable purchase price.
	Hospice services	20% coinsurance	40% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $100/appointment. ***Inpatient:*** Services from Non-Contract providers not registered with CMS are not covered. Covered if terminally ill. Respite care is limited to 8 days.
If your child needs dental or eye care	Children's eye exam	$10 copayment	$10 copayment	Vision benefits are available through a separate vision plan. Your cost sharing does not count toward the medical plan's out-of-pocket limit.
	Children's glasses	$25 copayment, plus all amounts over $175 for frames	$25 copayment, plus all amounts over $35 for single vision lenses and amount over $45 for frames	
	Children's dental check-up	No charge, a deductible does not apply to these services.		Limited to $2,500/person for Contract and $2,000/person for Non-Contract per calendar year. Dental benefits are available through a separate dental plan. Your cost sharing does not count toward the medical plan's out-of-pocket limit.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (up to $35/visit and 20 visits per calendar year)
- Bariatric surgery (with precertification)
- Chiropractic care (Employee and spouse only. Up to $25/visit up to 20 visits per calendar year)
- Dental care (Adult) (up to $2,500 for Contract and $2,000 for Non-Contract per calendar year)
- Hearing aids (limited to $800/ear in any 3-year period)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (under separate vision plan)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Trust Fund Office at 1-888-547-2054. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-547-2054.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-547-2054.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-888-547-2054.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (TTY: 711)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.carpenterfunds.com.

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$128**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$128
Copayments	$60
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$2,708

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$128**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$128
Copayments	$330
Coinsurance	$390
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$868

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$128**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$128
Copayments	$10
Coinsurance	$530
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$668

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see www.kp.org/plandocuments or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual / $3,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not Covered	None
	Specialist visit	$20 / visit	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs	Retail: $10 / prescription Mail order: $20 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs	Retail: $30 / prescription Mail order: $60 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	30% coinsurance up to $150 / prescription	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	None
	Emergency medical transportation	No Charge	No Charge	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
	Urgent care	$20 / visit	$20 / visit	Non-Plan providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral health: $20 / individual visit. No charge for other outpatient services Substance Abuse: $20 / individual visit. $5 / day for other outpatient services	Not Covered	Mental / Behavioral health: $10 / group visit. Substance Abuse: $5 / group visit.
	Inpatient services	$250 / admission	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	$250 / admission	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	Rehabilitation services	Inpatient: $250 / admission Outpatient: $20 / visit	Not Covered	None
	Habilitation services	$20 / visit	Not Covered	None
	Skilled nursing care	$250 / admission	Not Covered	Up to 100 days maximum / benefit period.
	Durable medical equipment	No Charge	Not Covered	Requires prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
	Hospice services	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	None
	Children's glasses	Frames: Amount in excess of $150 allowance; Lenses: No charge	Not Covered	Frame allowance limited to once every 24 months. Lenses limited to CR-39 clear plastic or polycarbonate (single vision, flat top multifocal, or lenticular).
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult and child)
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (plan provider referred)
- Bariatric surgery
- Chiropractic care (30 visit limit / year)
- Hearing aids ($2500 limit / ear every 36 months)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.healthhelp.ca.gov/

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 (TTY: 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-757-7585 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (TTY: 711)

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$250
Other (blood work) copayment	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$350**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$250
Other (blood work) copayment	$0

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$250
Other (x-ray) copayment	$0

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

The plan would be responsible for the other costs of these EXAMPLE covered services.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
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265 Hegenberger Road, Suite 100 ✧ P.O. Box 2280
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www.carpenterfunds.com

July 16, 2021

To: **All Active Participants and Dependents of the Carpenters Health and Welfare Trust Fund for California, including COBRA Beneficiaries**

From: **Board of Trustees**

Re: **Notice of Creditable Coverage**
Important Information about Medicare Prescription Drug Program (Part D)

This notice is for people with Medicare or who may become eligible for Medicare.
Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with Carpenters Health and Welfare Trust Fund for California and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members <u>are not now eligible for Medicare</u>, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members <u>are now eligible for Medicare or may become eligible</u> for Medicare in the next 12 months, you should read this Notice very carefully.**

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

<u>The Trust Fund has determined that the prescription drug coverage under the Carpenters Health and Welfare Trust Fund for California – Indemnity Medical Plan (as administered by Express Scripts) and the Kaiser Plan for Active Employees and Non-Medicare Retirees are "creditable." (the Kaiser Senior Advantage is an actual Medicare Part D plan and this notice does not apply to Participants who are covered by this plan.)</u>

Coverage is "Creditable" if the value of this Plan's prescription drug benefit equals or exceeds the value of the standard Medicare prescription drug coverage. In other words, the benefit is, on average for all plan participants, expected to pay out as much or more than the standard Medicare prescription drug coverage will pay.

Because the Plan option(s) noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can keep your prescription drug coverage under the Carpenters Health and Welfare Trust Fund for California Indemnity Medical Plan, and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment penalty).

REMEMBER TO KEEP THIS NOTICE

If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following three (3) times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months, and at other times in the future such if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage, you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

> If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 continuous days or longer without creditable prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE YOUR CHOICES?

You can choose either **one** of the following options:

OPTION 1

What you can do:
You can select or keep your current prescription drug coverage with Carpenters Health and Welfare Trust Fund for California Indemnity Medical Plan, and **you do not have to enroll in a Medicare prescription drug plan.**

What this option means to you:
You will continue to be able to use your prescription drug benefits through Carpenters Health and Welfare Trust Fund for California Indemnity Medical Plan.

- You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15 through December 7 of each year).
- As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment penalty) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.

OPTION 2

What you can do:
This option applies to Indemnity Medical Plan members only. You can select or keep your current Indemnity medical and prescription drug coverage with Carpenters Health and Welfare Trust Fund for California **and also enroll in a Medicare prescription drug plan.**

You will need to pay the Medicare Part D premium out of your own pocket.

What this option means to you:
For Indemnity Medical Plan Members Only: Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, and you are in the Indemnity Medical Plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under the Indemnity Medical Plan and Medicare means that you will still be able to receive all your current health coverage and this Plan will coordinate its drug payments with Medicare. This group health plan pays primary and Medicare Part D coverage pays secondary.

Note that you may not drop just the prescription drug coverage under the Indemnity Medical Plan of the Carpenters Health and Welfare Trust Fund for California. That is because prescription drug coverage is part of the entire medical Plan.

Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:

- PDPs may have different premium amounts;
- PDPs may cover different brand name drugs at different costs to you;
- PDPs may have different prescription drug deductibles and different drug copayments;
- PDPs may have different networks for retail pharmacies and mail order services.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help. (See your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Para mas información sobre sus opciones bajo la cobertura de Medicare para recetas medicas.

Revise el manual "Medicare Y Usted" para información detallada sobre los planes de Medicare que ofrecen cobertura para recetas medicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1-800-MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben de llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deben de llamar al 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Contact: Benefit Services Department
Carpenters Health and Welfare Trust Fund for California
Address: 265 Hegenberger Road, Suite 100, Oakland, CA 94621
Phone Number: (888) 547-2054

As in all cases, the Carpenters Health and Welfare Trust Fund for California and, when applicable, the insurance companies of the insured medical plan options offered by the Trust Fund reserves the right to modify benefits at any time, in accordance with applicable law. This document dated **July 16, 2021** is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
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www.carpenterfunds.com

July 16, 2021

To: **All Active Participants and Dependents of the Carpenters Health and Welfare Trust Fund for California, including COBRA Beneficiaries**

From: **Board of Trustees**

Re: **Important Information about Your Medical Plan**

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN YOUR HEALTH PLAN

Certain entities, including the trustees of a group health plan, are required by law to collect the Taxpayer Identification Number (TIN) or Social Security Number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. These entities are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a Social Security Number, visit http://www.socialsecurity.gov/online/ss-5.pdf for the form to request a SSN. Applying for a Social Security Number is FREE.

If you have not yet provided the Social Security Number (or other TIN) for each of your dependents enrolled in the health plan, please contact the Fund Office at (510) 633-0333 or toll free at (888) 547-2054.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI) REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Notice of Privacy Practices explains how the Carpenters Health and Welfare Trust Fund for California uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. To obtain another copy of this Notice write the Trust Fund Office in care of: HIPAA Privacy Officer, 265 Hegenberger Road, Suite 100, Oakland, CA 94621. You may also request a copy by calling (510) 633-0333, or toll free at (888) 547-2054 visiting our website at www.carpenterfunds.com, or emailing, benefitservices@carpenterfunds.com.

HIPAA Privacy Notices that pertain to the HMOs (prepaid medical and drug plans) may be obtained by contacting the HMO directly at the address provided in the Summary Plan Description or Evidence of Coverage, or by calling Kaiser at (800) 464-4000.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayments, and coinsurance applicable to other medical and surgical benefits under the various medical plans offered by the Carpenters Health and Welfare Trust Fund for California. For more information on WHCRA benefits, contact the Trust Fund Office or your medical plan directly at one of the following phone numbers:

Kaiser:	1(800) 464-4000
Indemnity:	1(888) 547-2054 (Claims Department)

SPECIAL EXTENSION OF COVERAGE FOR CERTAIN DEPENDENT STUDENTS ON A MEDICALLY NECESSARY LEAVE OF ABSENCE – MICHELLE'S LAW

This only applies to children of a Domestic Partner and children who are covered as a result of legal guardianship and must be full-time students in order to be covered after age 19.

If you have a dependent child that is over the age of 18 and is enrolled in a post-secondary institution (i.e. college or university) and the Plan receives a written certification from a covered child's treating physician that:

(1) the child is suffering from a serious illness or injury, and
(2) a leave of absence (or other change in enrollment) from a post-secondary institution is medically necessary, and the loss of postsecondary student status would result in a loss of health coverage under the Plan, then

the Plan will extend the child's coverage for up to one year.

This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the **earlier** of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan. Contact the Trust Fund Office at (510) 633-0333 or toll free at (888) 547-2054 for more information.

HOSPITAL LENGTH OF STAY FOR CHILDBIRTH

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician, after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization.

DISCLOSURE OF "GRANDFATHERED" STATUS

This group health Plan believes that the Fund's Indemnity Medical Plan is considered to be 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 already in effect when that law was enacted.

Being a grandfathered health plan means that certain consumer protections of the Affordable Care Act that apply to other plans may not be required. 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 Trust Fund Office at (510) 633-0333 or Toll Free at (888) 547-2054. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT (ENROLLED IN THE KAISER PLANS ONLY)

The Kaiser medical plan generally allows the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at 1-800-464-4000. Medicare Advantage Plans are subject to many of their own requirements, be sure to contact Kaiser at 1-800-464-4000 for more information about your Medicare Advantage Plan.

DIRECT ACCESS TO OBSTETRICAL / GYNECOLOGICAL PROVIDERS (KAISER PLANS ONLY)

You do not need prior authorization (pre-approval) from Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser at 1-800-464-4000. Medicare Advantage Plans are subject to many of their own requirements, be sure to contact Kaiser at 1-800-464-4000 for more information about your Medicare Advantage Plan.

REPORTING REQUIREMENTS UNDER THE AFFORDABLE CARE ACT AND STATE MANDATES

As required by the Affordable Care Act, each year, you will receive an IRS form (called Form 1095-B) in the mail if you or your dependents have been covered under a medical plan during the year. For each month of the calendar year that you were enrolled in a medical plan, Form 1095-B documents that you (and any enrolled family members) met the federal requirement to have "minimum essential coverage," meaning group medical plan coverage. Starting in 2020, you may have to pay a penalty if you do not have qualifying health insurance or an "exemption". The penalty will be applied by the California Franchise Tax Board when you file your state tax return. For information about the penalty, including the amount your family could owe for not having coverage, visit the Franchise Tax Board's website. If you live outside California, check with your State to see if a penalty applies.

If you receive a 1095 form, you will want to keep this form in a safe place because you may need to produce it if requested by the IRS. (For large employers, a copy of the form 1095 will also be provided to the IRS.)

Reminder: if you have not been covered by a medical plan during the last calendar year you will not receive a Form 1095-B. If you have been covered by various medical plans during the calendar year, you may receive more than one IRS form.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the following pages, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2021. Contact your State for further information on eligibility.

ALABAMA – Medicaid	**ALASKA –** Medicaid	**ARKANSAS -** Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (1-855-692-7447)
CALIFORNIA - Medicaid	**COLORADO** – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA** – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program https://dhcs.ca.gov/hipp Phone: 1-916-445-8322 Email: hipp@dhcs.ca.gov	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	**INDIANA** – Medicaid	**IOWA** – Medicaid and CHIP (Hawki)
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162 ext. 2131	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https:/dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone:1-888-346-9562
KANSAS – Medicaid	**KENTUCKY** – Medicaid	**LOUISIANA** – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicare hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS** – Medicaid and CHIP	**MINNESOTA** – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid	**MONTANA** – Medicaid	**NEBRASKA** – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178

NEVADA – Medicaid	**NEW HAMPSHIRE** – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 1-603-271-5218 Toll-Free number for the HIPP program: 1-800-852-3345, ext. 5218	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid	**NORTH CAROLINA** – Medicaid	**NORTH DAKOTA** – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON** – Medicaid	**PENNSYLVANIA** – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA** – Medicaid	**SOUTH DAKOTA** - Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH** – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON** – Medicaid	**WEST VIRGINIA** – Medicaid
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: http://mywvhipp.com/ Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING** – Medicaid	
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other States have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

CARPENTER FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100, Oakland, California 94621
(510) 633-0333 ▪ (888) 547-2054 ▪ fax (510) 633-0215 ▪ www.carpenterfunds.com

Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak

In light of the ongoing COVID-19 national emergency, certain deadlines currently established by the Plans will be extended to help prevent participants and beneficiaries from losing rights and benefits under the Plans. These extended deadlines relate to HIPAA special enrollment, COBRA and the filing of claims and appeals. In calculating the new deadline, the Plans will disregard the time period between March 1, 2020 and 60 days after the end of the COVID-19 national emergency. This time period is called the Outbreak Period in the examples below.

- ***HIPAA Special Enrollment.*** Participants will get extra time to exercise their special enrollment rights (e.g., enroll a new dependent or a dependent who loses eligibility for other coverage. For example, if this special enrollment event happened on or after March 1, 2020, the new deadline would be 30 days after the end of the Outbreak Period. If the special enrollment event relates to loss of coverage under Medicaid or the Children's Health Insurance Program, the new deadline would be 60 days after the end of the Outbreak Period.

- ***COBRA Continuation Coverage***. Participants will have additional time to notify the Plan of a qualifying event, submit a COBRA Election Form and make COBRA premium payments. For example, if the usual 60-day clock to submit the Election Form would start ticking on May 15, that clock would not start ticking until the end of the Outbreak Period. These deadline extensions do not extend the maximum period of COBRA coverage.

  If COBRA is elected and premiums are paid, claims for covered expenses will be paid retroactive to the first date of COBRA coverage, for every month for which premium are paid in full. The Plan will not pay any claims for medical expenses until COBRA is elected and COBRA premiums are paid in full.

- ***Filing Benefits Claims & Appeals.*** Participants will have additional time to file a claim for benefits, submit a request for an internal appeal and request an external appeal. In calculating the new deadlines, the Plans will disregard the days during the Outbreak Period.

If you have questions or would like more information about the dates that will apply to your rights under the Plans as they relate to special enrollment, COBRA or claims and appeals rights, please contact Benefit Services at the Fund Office at benefitservices@carpenterfunds.com, (510) 633-0333 or toll free at (888) 547-2054. Find forms and information on our website, www.carpenterfunds.com.

SUMMARY ANNUAL REPORT FOR
CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

Plan Year – September 1, 2019 through August 31, 2020

This is a summary of the annual report for the Carpenters Health and Welfare Trust Fund for California, Employer Identification Number 94-1234856, a multiemployer health and welfare plan, for the period September 1, 2019 through August 31, 2020. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California has committed the Fund to pay certain Medical, Hospital, Dental, Orthodontia, Prescription Drug, Vision, Hearing Aid, Physical Examination, Weekly Disability, Mental Health and Substance Abuse claims under the terms of the Plan.

Insurance Information:

The Plan has contracts with Kaiser Foundation Health Plan, Inc. to pay certain medical, hospital, mental health, substance abuse, and prescription drug claims, Voya Financial, Inc. to pay all accidental death, dismemberment, life insurance claims, and all stop loss claims incurred under the terms of the plan. The total premiums paid for all contracts for the Plan year ending August 31, 2020 were $288,691,387.

Basic Financial Statement:

The value of Plan assets, after subtracting liabilities of the Plan, was $743,506,933 minus premiums and self-funded claims payable of $71,448,658, minus claims incurred but not reported of $27,442,000, minus bank of hours liability of $161,833,000, equals $482,783,275 as of August 31, 2020, compared to $710,231,200 minus premiums and self-funded claims payable of $103,879,608, minus claims incurred but not reported of $19,273,000, minus bank of hours liability of $190,361,000, equals $396,717,592 as of September 1, 2019. During the Plan year, the Plan experienced an increase in its net assets of $86,065,683. This increase included unrealized appreciation or depreciation in the value of Plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year.

Condensed Financial Statement

Beginning Balance Value of Net Plan Assets	**As of 9/01/2018 $372,374,706**	**As of 9/01/2019 $396,717,592**
Employer Contributions	$473,925,952	$434,869,382
Participant Contributions	$32,116,564	$31,417,512
Investments - Earnings	$19,069,814	$1,078,845
Sale of Assets - Earnings/Losses	$4,128,350	$43,619,115
Other Income	$17,794,745	$24,568,101
Plan Income	**$547,035,425**	**$535,552,955**
Insurance Premiums	$320,282,470	$288,691,387
Self-Funded Benefits	$187,654,595	$146,475,198
Administrative Fees	$13,207,477	$12,802,578
Investment Expenses	$1,547,997	$1,518,109
Total Expenses	**$522,692,539**	**$449,487,272**
Ending Balance Value of Net Plan Assets	**As of 08/31/2019 $396,717,592**	**As of 08/31/2020 $482,783,275**

During the plan year, the Plan had total income of $535,552,955; including employer contributions of $434,869,382, participant contributions of $31,417,512, realized gains of $1,078,845 from the sale of assets, earnings from investments of $43,619,115, and other income of $24,568,101.

Plan expenses were $449,487,272. These expenses included $12,802,578 in administrative expenses, $1,518,109 in investment expenses, $288,691,387 in premium costs, and $146,475,198 in self-funded benefits paid directly to participants and beneficiaries or to service providers on their behalf.

Your Rights to Additional Information:

You have the right to receive a copy of the full annual report, or any part thereof, on request. The following items are included in that report: 1. an accountant's report; 2. financial information and information on payments to service providers; 3. assets held for investment; 4. fiduciary information, including non-exempt transactions between the plan and parties-in-interest (that is, persons who have certain relationships with the plan); 5. transactions in excess of 5 percent of the plan assets; and 6. insurance information including sales commissions paid by insurance carriers.

Obtaining Copies of a Summary Annual Report:

The report provided is a summary of the annual report filed for the Carpenters Health and Welfare Trust Fund for California. To obtain a copy of the full annual report or any part thereof, write or call the Carpenter Funds Administrative Office of Northern California, Inc., which is the Fund Manager appointed by the Plans' Administrator, at 265 Hegenberger Road, Suite 100, Oakland, California 94621; telephone (888) 547-2054. The charge to cover copying costs will be $15.00 for the full annual report, or $.25 per page for any part thereof.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or a statement of income and expenses of the Plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the Plan, 265 Hegenberger Road, Suite 100, Oakland, California 94621 and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

AVISO

Si usted tiene dificultad en entender alguna parte de este folleto, comuníquese con Carpenter Funds Administrative Office en 265 Hegenberger Road, Suite 100, Oakland, CA 94621. El horario de atención telefónica de las horas de Oficina del Fondo Fiduciario es de 8 la mañana a 5 de la tarde, de lunes a viernes. Usted también puede llamar a la oficina del Plan, teléfono 888-547-2054, para ayuda.

CARPENTERS HEALTH AND WELFARE
TRUST FUND FOR CALIFORNIA

carpenterfunds.com

265 Hegenberger Road, Suite 100
Oakland, California 94621-1480
Toll-Free: 1 (888) 547-2054
Phone: (510) 633-0333

July 23, 2021

TO: **All Plan Participants and their Dependents, including COBRA Beneficiaries**

FROM: **BOARD OF TRUSTEES**
Carpenters Health and Welfare Trust Fund for California

RE: **Indemnity Plan Benefit Changes**

- **Certain Specialty Oncology Drugs covered under the Medical Plan**
- **Level Care 90-day Supply Coverage**
- **PPO Telehealth extended through September 2021**
- **Long-term Care Exclusion**

This Participant Notice will advise you of material modifications that have been made to your Health and Welfare Plan benefits. This information is important to you and your Dependents. Please take the time to read it carefully.

INDEMNITY PLAN BENEFIT CHANGES

Certain Specialty Drugs covered under the Medical Plan (does not apply to Retirees who are eligible for Medicare)

In general, Specialty Drugs, as defined under the contract with the Pharmacy Benefit Manager (PBM), are only covered under the Plan's Mail Order Prescription Drug benefit. Some chemotherapy drugs are included in the Specialty Drug category.

Beginning July 1, 2021, you can choose to obtain the following Specialty Drugs under either the medical benefit of the Plan or the prescription drug program, however you are encouraged to explore the best option for you:

Brand	Generic
Zirabev or Mvasi	bevacizumab
Uplizno	ipilimumab
Keytruda	pembrolizumab
Herceptin	trastuzumab
Rituxan	rituximab
Prolia or Xgeva	denosumab
Opdivo	nivolumab
Lupron	leuprorelin

If you choose to obtain the Specialty Drug through the prescription drug program, it will be subject to the Specialty Drug copay listed below for up to a 30-day fill of the medication and is subject to prior approval by the PBM. After your physician obtains the prior approval from the PBM and depending on your preference, the drug will be mailed to you or to the provider administering the medication.

Formulary Generic Drug	$10 copay
Multi-Source Brand Name Drug	$26 plus the difference in cost between the generic and brand name Drug.
Single Source Formulary Brand Name	$53 copay
Non-Formulary Drug	$80 copay
Note: Any new Brand Name Drug approved by the FDA (including injectable and infusion drugs), the copay is 50% of the cost of the drug for a minimum of 24 months after the drug has been approved. If the PBM determines that the new FDA approved drug is a "must not add" drug, the copay will remain at 50% of the cost of the drug.	

If you elect to receive one of the specified Specialty Drugs through the medical benefit of the Plan, it will be subject to your calendar year deductible and coinsurance amounts and is subject to prior approval by Anthem's Utilization Management department. Once the prior approval is complete the medication can be provided by your attending physician instead of from the PBM.

Level Care 90-day Supply Coverage

Effective September 1, 2021, Level Care, in cooperation with Walgreen's retail pharmacy, will provide another option for obtaining maintenance drugs. In addition to the mail order program with the Plan's Pharmacy Benefit Manager (PBM), you may now choose to obtain maintenance drugs at Walgreen's pharmacy for the same cost as using mail order through this new 90-day drug supply program. To take advantage of this program, present your prescription card at the Walgreen's pharmacy and pay the same copayment as what you would have paid using the Plan's mail-order service with the PBM. You continue to have the option of obtaining your 90-day supply from the PBM's mail-order pharmacy for the mail-order copayment which many participants have found to be very convenient.

You may Contact the PBM, Express Scripts at (800) 473-3455 for additional information.

PPO Telehealth Visit Benefit extended through September, 2021

Last April, we informed you that the Plan will cover LiveHealth Online visits at 100% up to a maximum payment of $59, without deductible. We are pleased to advise you that the Plan will continue to provide this coverage through September 30, 2021. In addition, online telehealth visits with PPO providers are also covered by the Plan, subject to the Plan's regular deductible and coinsurance.

Long-term Care Exclusion effective September 1, 2021

The Fund currently excludes "custodial care". This includes charges for helping a person with the activities of daily living (for example, assistance with eating, using the toilet, bathing, getting dressed or out of bed, moving around, among others, that can safely be provided by caregivers with no medical training).

There may be limited circumstances where a patient may be receiving some custodial care in conjunction with medically necessary long-term medical rehabilitation. In order to address these limited circumstances, the Fund has clarified the custodial care exclusion to consider limited benefits in a long-term acute care facility when a patient is receiving rehabilitation therapy immediately after or instead of an acute inpatient hospitalization. For the Plan to consider such services, the patient must continue to make treatment progress as documented by patient notes. In addition, services must be authorized by Anthem's Utilization Review department, and will be paid pursuant to the Plan rules.

Because this Plan is a “grandfathered health plan,” we are required by law to provide this notice to you:

Grandfathered Health Plan: The Board of Trustees of the Carpenters Health and Welfare Trust Fund for California believes the Indemnity Medical 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 preventative 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 or the 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 keep this notice with your benefit booklet. If you have any questions, please contact Benefit Services at the Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to benefitservices@carpenterfunds.com. Forms and information can be found on our website at www.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.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan.