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.

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- **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.

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- **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.

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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.

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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

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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

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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.

CARPENTERS ANNUITY TRUST FUND AND
CARPENTERS VACATION AND HOLIDAY TRUST FUND
FOR NORTHERN CALIFORNIA
265 Hegenberger Road, Suite 100
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com ✧ benefitservices@carpenterfunds.com

April 17, 2018

Re: Carpenters Annuity Trust Fund for Northern California
Carpenters Vacation and Holiday Trust Fund for Northern California
Fee to Locate Missing Participants

Dear Participant and Beneficiary:

To ensure that you receive your benefits when eligible, the Trustees of the Carpenters Annuity Trust Fund and Vacation and Holiday Trust Fund have policies to locate and pay benefits to unenrolled and missing Participants or Beneficiaries of the Plans. The process of enrolling or locating missing Participants or Beneficiaries can include one or more of the following efforts, depending on the amount of the unpaid account balance:

- Write the Participant letters requesting enrollment in the Plan(s),
- Contact the Employer or former employer(s) to obtain an address,
- Contact the Union to obtain an address,
- Send information to an external commercial locator service that has access to a variety of sources to obtain an address.

In recognition of the cost of such efforts, the Plan(s) will assess Individual Account(s) a reasonable fee for the location services. To avoid an assessment for location efforts, simply keep the Fund Office apprised of your current address and if you have not yet done so, complete an Enrollment Form, which can be downloaded from the website, www.carpenterfunds.com, and mail, email, or fax it to the Carpenter Fund Office. You can also obtain a Form by calling the Fund Office at (888) 547-2054.

The Boards of Trustees maintain the right to change or discontinue the types and amounts of benefits under these Plans. This notice is intended as a summary only, and actual Plan documents will be used to interpret the Plans. Only the Full Boards of Trustees are authorized to interpret the Plans. The Boards have discretion to decide all questions about the Plans, 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 the Plans on behalf of the Boards or to act as an agent of the Boards.

Please keep this important notice with your Annuity and Vacation and Holiday benefit booklets. If you have any questions regarding this notice, please contact the Trust Fund Office at benefitservices@carpenterfunds.com, (510) 633-0333, or toll-free at (888) 547-2054.

Sincerely,

Carpenters Annuity Trust Fund Board of Trustees and
Carpenters Vacation Trust Fund Board of Trustees

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 PENSION TRUST FUND
FOR NORTHERN CALIFORNIA
265 Hegenberger Road, Suite 100
Oakland, California 94621
(510) 633-0333 ▪ (888) 547-2054
www.carpenterfunds.com

October 7, 2019

TO: Participants and Beneficiaries that Retired between September 1, 2017 through August 31, 2018

RE: Pension Plan Supplemental Benefit Payment

The Fund Office has been made aware of a typographical error in the Notice mailed to you on September 3, 2019. That Notice advised you of a modification to the Pension Plan that permitted a distribution of a supplemental Pension payment to certain Retirees and Surviving Spouses who qualified. Retirees and Surviving Spouses who qualified for the supplemental Pension payment had to meet the following requirements:

- The Retiree must have a retirement date on or before August 31, 2017, and
- The Retiree or Surviving Spouse must have been entitled to a monthly Pension benefit payment on July 1, 2019, and
- The Retiree's Pension benefit must be based on at least 12 full Northern California Eligibility or Vesting Credits (excluding any Eligibility Credits based on Related Credits earned under a Related Plan), and
- The Retiree was a member in good standing with a local union affiliated with the United Brotherhood of Carpenters and Joiners of America on January 1, 2019. For Surviving Spouses, the Retiree must have been a member in good standing with a local union affiliated with the United Brotherhood of Carpenters and Joiners of America on the date of his/her death.
- For Surviving Spouses, the Pension benefit payment must be based on a Joint and Survivor Pension.

The September 3, 2019 Notice inadvertently stated the Retiree must have a retirement date on or before August 31, 2018, however, the benefit was made available to qualified Retirees who had a retirement date on or before August 31, 2017. We regret any inconvenience the typographical error may have caused you.

Although your retirement date did not qualify for the supplemental benefit payment in 2019, your retirement date may be eligible for a future supplemental benefit payment if the Fund earnings are more than 8% on investments as of the Fiscal Year End each subsequent August 31st. If earnings are more than 8%, a supplemental benefit may be made under the same criteria as the 2019 payment, except that each date shall be advanced by one year. In the aggregate, the total of all issued supplemental checks on and after September 1, 2019 will not exceed $24.5 million.

Our Benefit Services Department is available at benefitservices@carpenterfunds.com, (510) 633-0333 and Toll Free at (888) 547-2054, to assist with any questions you may have regarding this Notice.

In accordance with ERISA reporting requirements,
This document serves as your Summary of Material Modifications to the Plan.
Please keep it with your Summary Plan Description.

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.

* * * * *

Because this Plan is a “grandfathered health plan,” the law requires 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 “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.

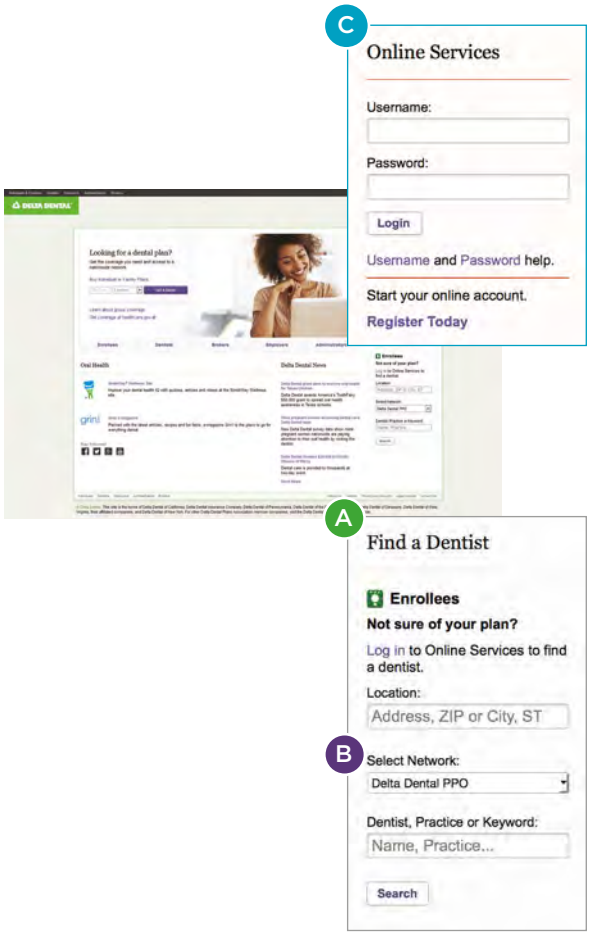
The Board of Trustees maintains the right to change or discontinue the types and amounts of benefits under this Plan. This notice is intended as a summary only, and actual Plan documents will be used to interpret the Plan. Only the full Board of Trustees is authorized to interpret the Plan. The Board 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.

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.

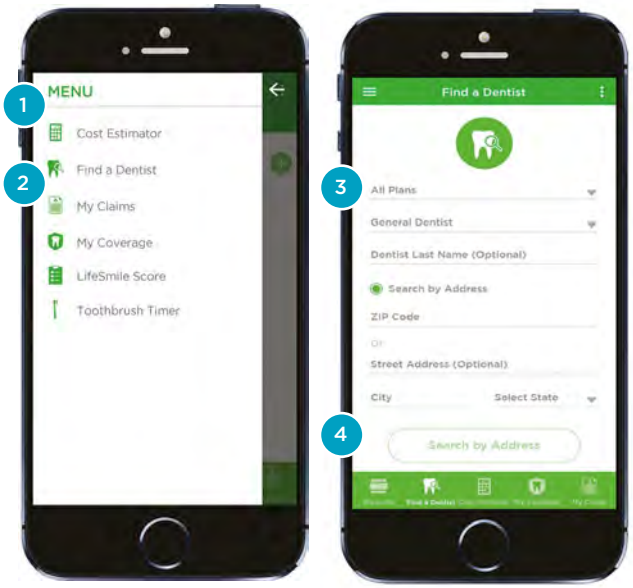
C. **Find out your network.** Don't know which network you're in? Log in to Online Services before searching. You can register for an account as soon as your coverage begins.

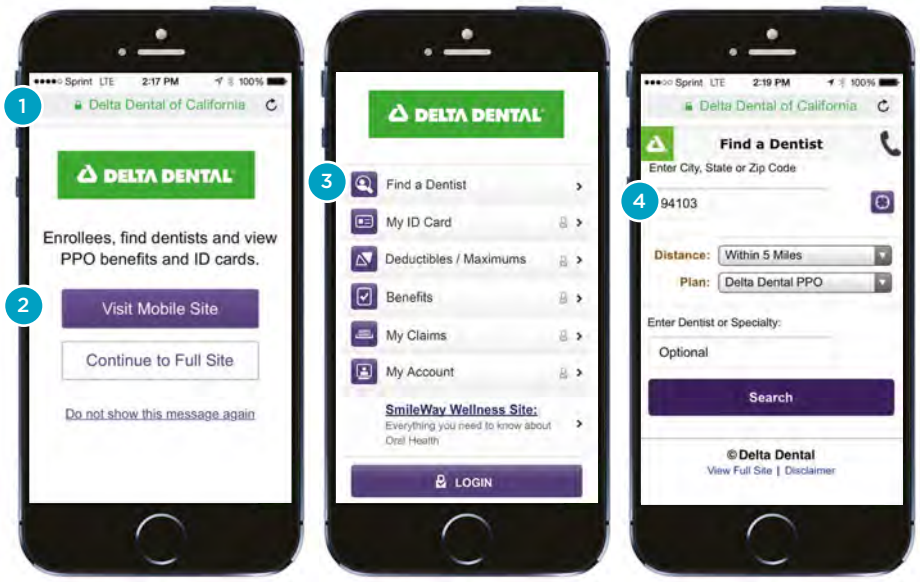
MOBILE APP[1]:

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.

* * * * *

Because this Plan is a "grandfathered health plan," federal law requires us 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 Fund's 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.

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Northern California Carpenters 401(k) Plan

CARES ACT – RETIREMENT PLAN PROVISIONS MEMO

Congress recently passed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). A portion of this act expands access to retirement plan accounts for affected Americans during this unprecedented time. While we encourage you to stay the course and continue to save, taking a loan or withdrawing money from your retirement account may be something you are considering as a last resort. If you decide you need to access your 401(k) Plan, your plan has adopted the following provisions.

Carpenter Funds Administrative Office, together with Pensionmark Financial Group, has consistently worked to provide the utmost educational experience for all its participants.

PARTICIPANT EDUCATION

We believe that it is critical for employees to have access to responsive, live staff to assist them in navigating their retirement plan strategy. Registered and bilingual specialists are available. Our call center hours are Monday through Friday from 8:30 A.M. to 5:00 P.M. (PST).

NEED HELP?

For more details or if you have questions regarding the CARES Act or any of your 401(k) Provisions, both Pensionmark and John Hancock are fully operational and here to assist you.

Access your account at
www.mylife.jhrps.com
or call 1-833-388-6466

If you would like to speak to someone from Pensionmark's Wellness team:
Email: info@pensionmark.com
Phone: 1-888-201-5488

The CARES ACT Relief Provisions apply to:

- A person diagnosed with COVID-19 by a test approved by the Centers for Disease Control and Prevention.
- A person with a spouse or dependent diagnosed with COVID-19.
- A person experiencing adverse financial consequences due to being furloughed, quarantined, laid off, had their paid work hours reduced, were unable to work due to lack of childcare or had to close or scale back a business due to the coronavirus.

Retirement Plan Loans

For any new or existing loan, you may apply to suspend your repayments due between March 27, 2020, and December 31, 2020. All subsequent payments will be adjusted to account for the delay and interest accrued during the delay.

- If making loan repayments **via ACH or mail, you may call 1-833-388-6466 or 1-833-388-6466** to certify that you wish to delay payment due to COVID eligible repayment suspension provisions.

Invoices will continue to be mailed but you can choose to not to pay them in the suspension period.

Withdrawals/Distributions

You may withdraw 100% of your 401(k) account up to $100,000. (The maximum combines with other qualified accounts you may own.) The IRS suspended early withdrawal penalties for those taking CARES Act related distributions. These withdrawals are still taxable as income, but the tax can be spread over three years and you can elect to repay the withdrawal within three years. Additionally, the 20% standard income tax withholding at the time of distribution is not required. **We recommend discussing your options with a tax professional.**

To request a COVID-Related Distribution, once logged into your participant website:

1. Navigate to the Mega Menu drop down at the top of the home page.
2. Upon opening the Mega Menu, on the bottom left hand corner of the menu under "About my plan", click on "Request Forms".
3. On the Request forms screen, choose the "Coronavirus-Related Distribution" and elect to have the form either emailed or sent via mail.

Pensionmark has a wealth of free tools and resources available to you at www.pensionmark.com/financial-wellness-center/. Before making decisions about taking money out of your retirement savings, please reach out to your dedicated Pensionmark team. We are here to help you navigate through this unprecedented time. Please stay healthy and safe!

Pensionmark Financial Group does not provide tax or legal advice. Please consult with a tax professional prior to deciding on any distribution option.

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.

* * * * *

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.

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

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.

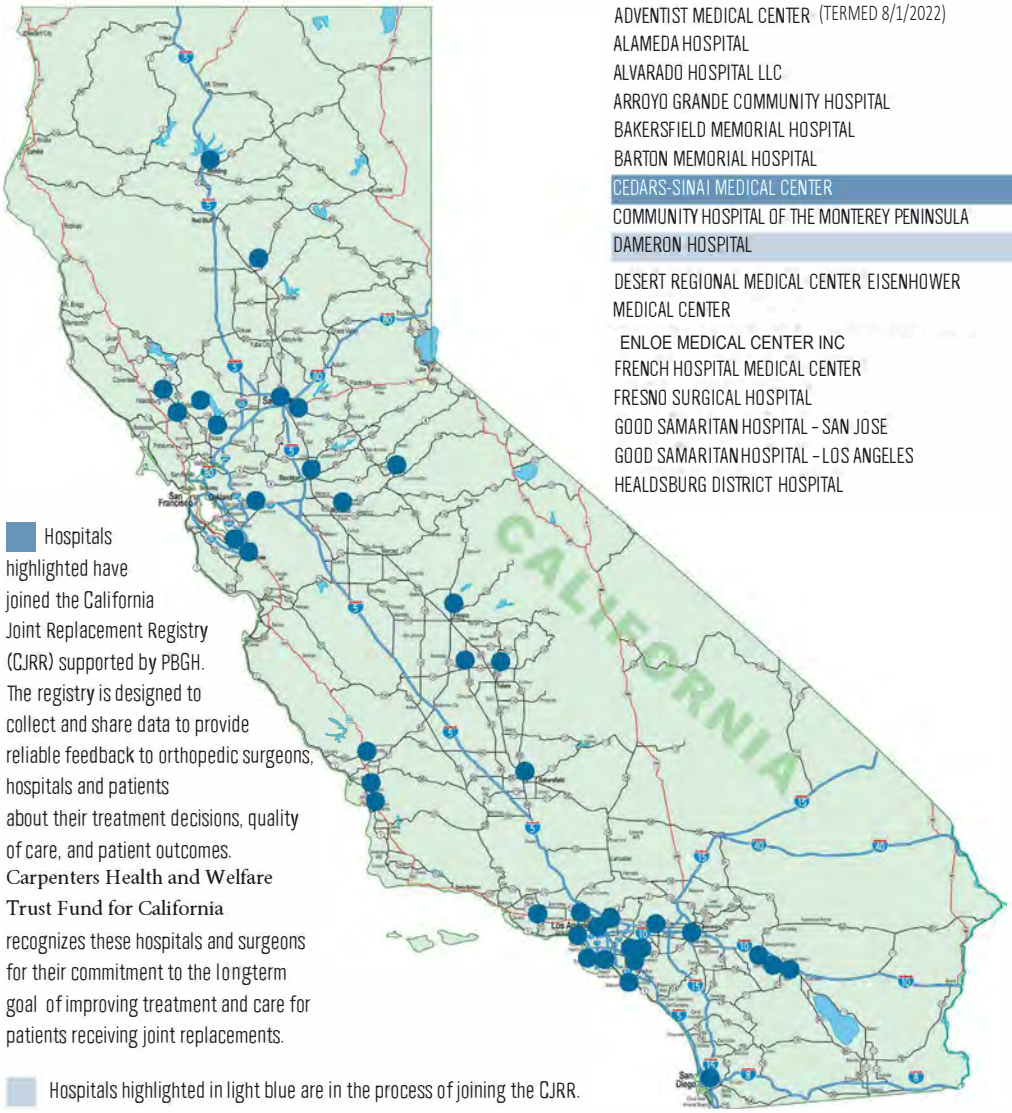
This program limits payment to $30,000 maximum for single hip joint replacement or single knee joint replacement surgeries. **Carpenters Health and Welfare Trust Fund for California** and Anthem have identified 53 facilities throughout California where you can have these surgeries done with little to 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 (TERMED 8/1/2022)
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
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
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

* * * * *

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

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"*.

Benefit Snapshot		
Service	**During Public Health Emergency**	**After Public Health Emergency** (Restrictions Lifted)
COVID-19 Vaccines **Flu Vaccines** **Other Immunizations**	Effective 1/1/2021: Participant Cost: $0 *Receive immunizations from any Medical Provider or Contract Pharmacy*	Participant Cost: $0 *Must use a PPO Contract Provider or Express Scripts Contract Pharmacy*
COVID-19 Laboratory Tests	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.*	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.*
Finding a Contract Provider	**Medical Providers** Anthem (800) 810-2583 or www.anthem.com **Contract Pharmacy for Immunizations** Express Scripts (800) 939-7093 or www.express-scripts.com	

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 PENSION TRUST FUND
FOR NORTHERN CALIFORNIA **carpenterfunds.com**

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

June 11, 2021

TO: All Participants and Beneficiaries

FROM: Board of Trustees

RE: Carpenters Pension Trust Fund for Northern California
- **Percentage of Contribution Accrual Factor**
- **Change to the Required Beginning Date**

This notice is to advise you of modifications that have been made to the Pension Plan for the Carpenters Pension Trust for Northern California.

Percentage of Contribution Accrual Factor

Effective July 1, 2021 and July 1, 2022, the Collective Bargaining Agreement provides for increases in the contributions paid into the Carpenters Pension Trust Fund for Northern California ("Pension Fund"). Even though the Scheduled Contribution Rate for Pension is increasing, in order to keep the Monthly Benefit at approximately the same amount each year, the Accrual Rate Percentage of Contribution Factor will continue to decrease as shown in the table below. The new money is intended to increase the financial stability of the Pension Fund by paying more towards unfunded liabilities. The same number of Hours in Covered Employment will continue to earn approximately the same dollar value benefit each year.

These changes do not affect benefits earned prior to July 2021. *If you are currently retired and receiving a monthly benefit payment from the Pension Fund, your payments will continue uninterrupted.*

Effective Dates	Scheduled Contribution Rate	Percentage of Contribution Accrual Factor	(Example) Monthly Benefit, Assuming 1,740 Hours
July 1, 2021 to June 30, 2022	$10.95	1.10%	$209.58
July 1, 2022 to June 30, 2023	$11.10	1.085%	$209.56

Change to the Required Beginning Date

The Required Beginning Date is the date as of which federal law requires Participants to commence benefits under the Plan. Participants who do not apply for benefits on or before their Required Beginning Date will be paid in the form of a 50% Joint and Survivor calculation and they cannot change to another payment election unless proven to be unmarried.

Effective January 1, 2020, if you were born on or after July 1, 1949, your Required Beginning Date is April 1 of the calendar year following the calendar year in which you attain age 72. If you were

born before July 1, 1949, your Required Beginning Date remains April 1 of the calendar year following the calendar year in which you attain age 70½.

If you die before your benefits have begun, federal law also states when your surviving Spouse (if any) is required to commence benefits under the Plan. Effective January 1, 2020, surviving Spouses of Participants born on or after July 1, 1949 are required to begin distributions by December 31 of the calendar year in which you would have reached 72. Surviving Spouses of Participants born before July 1, 1949, must still begin distributions by December 31 of the calendar year in which you would have reached age 70½.

Although the Required Beginning Date under the Plan has changed, you may still elect to begin receiving benefits at age 70½, even if you are employed in any capacity.

For more information about this notice or the Pension Plan in general, please contact the Trust Fund Office at benefitservices@carpenterfunds.com or by mail at Carpenter Funds Administrative Office of Northern California, Inc., 265 Hegenberger Rd., Suite 100, Oakland, CA 94621.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan. Please keep it with your Summary Plan Description.

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.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC. carpenterfunds.com

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

October 1, 2021

TO: **All Plan Participants and Beneficiaries**

FROM: **BOARD OF TRUSTEES**
Northern California Carpenters 401(k) Trust Fund

RE: **Plan Changes**
- **Rules For Participation**
- **Setting Every Community Up for Retirement Enhancement Act of 2019 (SECURE ACT)**
- **Coronavirus Aid, Relief and Economic Security Act (CARES Act)**

The purpose of this Notice is to notify you of changes made to the Northern California Carpenters 401(k) Plan (the "401(k) Plan") due to changes in rules for participation in the 401(k) Plan, the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") and the Setting Every Community Up for Retirement Enhancement Act of 2019 (the "SECURE Act").

This Notice is a Summary of Material Modifications ("SMM") to the Summary Plan Description ("SPD"), and supplements the IRS Safe-Harbor Plan Notice previously distributed for the current Plan Year.

Please read this carefully and keep it with your copy of the SPD which was previously distributed to you. If you have questions, call John Hancock or the 401(k) Plan contact listed in your SPD.

CHANGES IN RULES FOR PARTICIPATION

Eligibility to Participate if you are working under a Collective Bargaining Agreement

If you are working under a Collective Bargaining Agreement, you are eligible to participate in the 401(k) Plan if your Employer is making a contribution to the Carpenters Annuity Trust Fund for Northern California that is at least 3% of your pay as reported on the Form W-2. If your Employer is not making any Annuity Contributions, or is making an Annuity Contribution that is less than 3% of your pay, you are not eligible to participate in the 401(k) Plan.

Eligibility to Participate if you are a Non-Collectively Bargained Employee working for an Employer who has signed a Collective Bargaining Agreement or Subscription Agreement allowing participation in the 401(k) Plan

If you are a Non-Collectively Bargained Employee working for an Employer who has signed a Collective Bargaining Agreement or Subscription Agreement allowing participation in the 401(k) Plan, you are eligible to participate in the 401(k) Plan if your Employer is making, or will make, a contribution to the Carpenters Annuity Trust Fund for Northern California and/or the 401(k) Plan that is at least 3% of your pay as reported on the Form W-2.

SECURE ACT CHANGES

Change to the Required Beginning Date:

The Required Beginning Date is the date which federal law requires that Participants begin receiving benefits under the 401(k) Plan. Effective January 1, 2020, if you were born on or after July 1, 1949, your Required Beginning Date is April 1 of the calendar year following the calendar year in which you attain age 72. If you were born before July 1, 1949, your Required Beginning Date remains April 1 of the calendar year following the calendar year in which you attain age 70½.

If a Participant dies without taking any distributions, federal law also stipulates the Required Beginning Date in which a surviving Spouse (if any) is required to begin receiving benefits under the Plan. Effective January 1, 2020, surviving Spouses of Participants born on or after July 1, 1949 are required to begin distributions by December 31 of the calendar year in which the Participant would have reached 72. Surviving Spouses of Participants born before July 1, 1949 must still begin distributions by December 31 of the calendar year in which the Participant would have reached age 70½.

Timing of Beneficiary Distributions:

Plan changes have been made regarding the timing of payments to be made to Beneficiaries when a Participant passes away before receiving his or her entire 401(k) account. These changes have been made to align with recent Federal Law.

Upon the death of a Participant, effective January 1, 2020, following is information regarding the options and timing of payment requirements that would apply to a Participant's Beneficiary (or Beneficiaries):

TYPE OF BENEFICIARY:	BENEFICIARY PAYMENT INFORMATION:
Spouse, Disabled Beneficiary, Chronically Ill Beneficiary, or a Beneficiary who is not more than 10 years younger	Option 1: The Beneficiary must have received the Participant's entire interest no later than end of the calendar year containing the 10th anniversary of the Participant's death.
	Option 2: The Beneficiary can elect a life annuity, which must begin no later than December 31 of the year immediately preceding the Participant's Required Beginning Date. This option must be elected before September 30 in the year after the Participant's death.
Minor Child	The Beneficiary must receive the Participant's entire interest no later than end of the calendar year containing the 10th anniversary of the Minor Child reaching the age of majority.
Applicable Multi-Beneficiary Trust (AMBT)	The Beneficiary must receive the Participant's entire interest no later than end of the calendar year containing the 10th anniversary of the Participant's death, except in the case of an AMBT with disabled and/or chronically ill Beneficiaries, where a life annuity may be chosen if elected by September 30 in the year after the Participant's death.
Designated Beneficiary not mentioned above	The Beneficiary must receive the Participant's entire interest no later than end of the calendar year containing the 10th anniversary of the Participant's death
A Non-Designated Beneficiary	The Beneficiary must receive the Participant's entire interest no later than end of the calendar year containing the 5th anniversary of the Participant's death.

CARES ACT CHANGES

Definition of Qualified Individual

Certain changes to the 401(k) Plan apply only to those Participants who are defined as "Qualified Individuals" under the provisions of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).

A Participant of the 401(k) Plan would be a "Qualified Individual" upon certification of one of the following conditions any time during the period January 1, 2020 through December 31, 2020:

- The Participant, Participant's spouse or dependent (as defined in Section 152 of the Internal Revenue Code) was diagnosed with the Virus SARS-CoV-2 or COVID-19 by a test approved by the Centers for Disease Control and Prevention, or
- the Participant has experienced adverse financial consequences because the Participant, his spouse, or a member of his household:
    - were quarantined, furloughed or laid off, or had work hours reduced due to COVID-19; or
    - were unable to work due to lack of childcare due to COVID-19; or
    - had a reduction in pay (or self-employment income), had a job offer rescinded or start date for a job delayed due to COVID-19; or
    - owned or operated a business which closed or hours were reduced due to COVID-19.

The IRS may, in the future, expand the definition of Qualified Individual.

Coronavirus-Related Distributions for Qualified Individuals

A Coronavirus-Related Distribution ("CRD") is a distribution made from an eligible retirement plan to a Qualified Individual from January 1, 2020, to December 30, 2020, for up to a combined limit of $100,000 from all eligible retirement plans and IRAs in which the Qualified Individual participates.

For federal income tax purposes, the amount of a CRD can be included as income in the year received, or over a three (3) year period (state tax treatment may differ). Note: Whichever method is chosen must be applied to all CRDs received in the taxable year and cannot be changed after the required date for filing your tax return (including extension) for the year of distribution. In addition, all or a portion of a CRD may be repaid to an eligible retirement plan that accepts such repayment or to an IRA, but only during the three (3) year period beginning on the day after the date the CRD was received (and prior federal income tax filings can be amended to reflect the repayment). Any repayment is treated under the 401(k) Plan as a rollover contribution. There is no 10% early withdrawal penalty tax and the CRD is subject to optional federal income tax withholding. State income tax and withholding may also apply.

If you are a Qualified Individual and you take a distribution other than a CRD (or have a loan offset) from the 401(k) Plan in 2020 and before December 30, 2020, you may also be able to treat that distribution as a CRD when you file your federal tax return. Consult your tax advisor for more information.

It is solely your responsibility to make sure that if you had a CRD from the Northern California 401(k) Plan, that it and any other CRDs from eligible retirement plans and IRAs in which you participate, do not exceed $100,000.

CRDs will be made in accordance with procedures established by the Plan Administrator.

Suspension of Loan Repayments for Qualified Individuals

If you are a Qualified Individual and have a loan with the 401(k) Plan, you were permitted an option to request the suspension of loan repayments due between March 27, 2020 and December 2020. When loan repayments resumed again (early 2021), the repayment amounts would have been adjusted as the remaining loan repayments will be made up over the original term of the loan plus up to one year and will include accrued interest. For information concerning your loan or loan payment call John Hancock at the phone number provided in your SPD.

Suspension of 2020 Required Minimum Distributions ("RMDs") *See Secure Act Changes*

If 2019 was the first year you would have been required to receive an RMD and you received the 2019 RMD during the period of January 1, 2020 through April 1, 2020, you were permitted to roll over the distribution, to an eligible retirement plan that accepts rollovers or an IRA, until August 31, 2020.

If 2020 was not the first year of your RMD you would have received your 2020 RMD unless you had elected to suspend your 2020 RMD by contacting John Hancock.

If 2020 was the first year of your RMD you would not have received your 2020 RMD unless you had elected to do so by contacting John Hancock.

If you received a RMD in 2020, you were permitted to roll it over to an eligible retirement plan that accepts rollovers or an IRA. The rollover must have been made within 60 days of the distribution (or August 31, 2020, if later).

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
carpenterfunds.com

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

October 1, 2021

TO: **All Participants and Beneficiaries**

FROM: **BOARD OF TRUSTEES**
Carpenters Annuity Trust Fund for Northern California

RE: **Plan Changes**
- **Joint and 100% Survivor Annuity**
- **Changing Required Beginning Date**
- **Required Minimum Distribution waived 2020**
- **Timing of Beneficiary Distributions**
- **Correction to 2020 Fee Disclosure Document**

The purpose of this Notice is to notify you of changes made to the Carpenters Annuity Plan. This Notice is a Summary of Material Modifications ("SMM") to the Summary Plan Description ("SPD")

Joint and 100% Survivor Annuity:

Effective September 1, 2021, if you are a married Participant and become eligible to receive a distribution of your Annuity Plan Accumulated Share, you may elect to receive payment in the form of a Joint and 100% Survivor Annuity. Under the Joint and 100% Survivor Annuity, the monthly amount to be paid to your surviving Spouse is 100% of the monthly amount which was payable during your lifetime. As with the Joint and 50% Survivor Annuity and the Joint and 75% Survivor Annuity, the benefit payments under the Joint and 100% Survivor Annuity will be adjusted but will be the Actuarial Equivalent at the time of your Retirement. This is a new form of payment added to the Plan. All other payment options are still available.

Change to the Required Beginning Date:

The Required Beginning Date is the date which federal law requires that Participants begin receiving benefits under the Annuity Plan. Effective January 1, 2020, if you were born on or after July 1, 1949, your Required Beginning Date is April 1 of the calendar year following the calendar year in which you attain age 72. If you were born before July 1, 1949, your Required Beginning Date remains April 1 of the calendar year following the calendar year in which you attain age 70½.

If a Participant dies without taking any distributions, federal law also stipulates the Required Beginning Date in which a surviving Spouse (if any) is required to begin receiving benefits under the Plan. Effective January 1, 2020, surviving Spouses of Participants born on or after July 1, 1949 are required to begin distributions by December 31 of the calendar year in which the Participant would have reached 72. Surviving Spouses of Participants born before July 1, 1949 must still begin distributions by December 31 of the calendar year in which the Participant would have reached age 70½.

Required Minimum Distributions Waived for 2020:

Federal law allowed Participants who otherwise would have been required to receive Required Minimum Distributions in 2020 the option to either waive distributions or make an election to receive distribution from their account. This change formally documents the waiver permitted by law that the Plan followed in 2020. No additional action is required on your part at this time.

Timing of Beneficiary Distributions:

Plan changes have been made regarding the timing of payments to be made to Beneficiaries when a Participant passes away before receiving his or her entire Annuity account. These changes have been made to align with recent Federal Law.

Upon the death of a Participant, effective January 1, 2020, following is information regarding the options and timing of payment requirements that would apply to a Participant's Beneficiary (or Beneficiaries):

TYPE OF BENEFICIARY:	BENEFICIARY PAYMENT INFORMATION:
Spouse, Disabled Beneficiary, Chronically Ill Beneficiary, or a Beneficiary who is not more than 10 years younger	Option 1: The Beneficiary must have received the Participant's entire interest no later than end of the calendar year containing the 10th anniversary of the Participant's death.
	Option 2: The Beneficiary can elect a life annuity, which must begin no later than December 31 of the year immediately preceding the Participant's Required Beginning Date. This option must be elected before September 30 in the year after the Participant's death.
Minor Child	The Beneficiary must receive the Participant's entire interest no later than end of the calendar year containing the 10th anniversary of the Minor Child reaching the age of majority.
Applicable Multi-Beneficiary Trust (AMBT)	The Beneficiary must receive the Participant's entire interest no later than end of the calendar year containing the 10th anniversary of the Participant's death, except in the case of an AMBT with disabled and/or chronically ill Beneficiaries, where a life annuity may be chosen if elected by September 30 in the year after the Participant's death.
Designated Beneficiary not mentioned above	The Beneficiary must receive the Participant's entire interest no later than end of the calendar year containing the 10th anniversary of the Participant's death
A Non-Designated Beneficiary	The Beneficiary must receive the Participant's entire interest no later than end of the calendar year containing the 5th anniversary of the Participant's death.

Participant Directed Investment Only:

Correction to 2020 Carpenters Annuity Trust Fund for Northern California Fee Disclosure Notice

Effective January 1, 2019, the annual pro-rata administrative fee was reduced from 0.33% to 0.28%. In the Fee Disclosure Document distributed to Annity Plan Participants in July of 2020, the estimated pro-rata administrative fee in Section 3 was misstated as 0.33% and should have been reported as 0.28%. This was a typographical error, and the reduced fee was correctly applied. Your Individual Account was not negatively impacted.

For more information about this notice or the Annuity Plan in general, please contact the Trust Fund Office at benefitservices@carpenterfunds.com or by mail at Carpenter Funds Administrative Office of Northern California, Inc., 265 Hegenberger Rd., Suite 100, Oakland, CA 94621.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan. Please keep it with your Plan Description.

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

January 14, 2022

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 Changes
- **Women's Preventive Care Services**
- **Vaccines and Immunizations**

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

Women's Preventive Care Services

Women's preventive care services received on or after January 1, 2022 (for an Employee or Spouse), will be covered at 100% (no deductible) with a Contract Provider. This includes one routine Ob-Gyn examination within a 12-month period. Coverage also includes any x-rays and laboratory tests provided in connection with the physical examination, including a pap smear and routine mammogram.

Vaccines and Immunizations

At this time, vaccines and immunizations (including travel immunizations), included in the Express Scripts comprehensive vaccine coverage program are covered at 100%, with no copayment when received from a Participating Pharmacy.

Effective for the following vaccines and immunizations received on or after January 1, 2022, you will have the choice of receiving benefits for the following vaccines and immunizations at a Participating Pharmacy or with a Contract Provider. If you receive the following vaccines and immunizations with a Contract Provider, they will be covered at 100% (no deductible or coinsurance):

a. Vaccines and immunizations for adults—doses, recommended ages, and recommended populations must be satisfied:

- Diphtheria/tetanus/pertussis
- Measles/mumps/rubella (MMR)
- Influenza
- Human papillomavirus (HPV)
- Pneumococcal (polysaccharide)
- Zoster
- Hepatitis A
- Hepatitis B
- Meningococcal
- Varicella
- COVID-19

b. Vaccines and immunizations for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:

- Hepatitis B
- Rotavirus
- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Pneumococcal
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella
- Varicella
- Hepatitis A
- Meningococcal
- Human papillomavirus (HPV)
- COVID-19

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
Oakland, California 94621
(510) 633-0333 ▪ (888) 547-2054
www.carpenterfunds.com

March 1, 2022

RE: Carpenters Pension Trust Fund for Northern California
Carpenters Annuity Trust Fund for Northern California
Income Tax Withholding

Dear Retiree/Beneficiary:

As a reminder, you may choose the number of withholding allowances used to determine how much federal income tax is withheld from your retirement payments. You may also elect to have no withholding.

In 2022, the automatic federal income tax withholding threshold for monthly benefits is $2,165. If you wish to change your income tax deductions you must submit a new *Form W-4P Withholding Certificate for Pension or Annuity Payments*.

If your monthly Retirement Payments are less than $2,165 per month in 2022
• We *will not* automatically withhold federal taxes • You may elect withholding if you like • If you previously requested withholding, we will continue to withhold taxes

If your monthly Retirement Payments are greater than $2,165 per month in 2022
We ***will*** automatically withhold federal taxes assuming "Married, 3 exemptions". However, you may elect withholding based on the following: • A different marital status, and/or • A different number of exemptions, or • No withholding at all • If you previously requested withholding, we will continue to withhold taxes Exception: If the Fund Office has no U.S. street address on record, a Retiree is subject to mandatory withholding at "Married, 3 exemptions" regardless of the Retiree's request for an alternative, lower withholding rate.

If you are a California resident, we will automatically withhold state taxes if 10% of the amount of federal withholding is at least $10. You may elect to withhold a different amount or no withholding at all for state personal income tax by completing a DE-4P form. If you elect to have state taxes withheld, you can change or cancel withholding instructions at any time.

To obtain a federal W-4P Withholding Form or California State DE-4P Form:

- Contact the Fund Office Benefit Services Department
  Phone: (510) 633-0333 or Toll Free at (888) 547-2054
  Email: benefitservices@carpenterfunds.com, or
  Visit: www.carpenterfunds.com/forms-and-documents/
- **Visit the Internal Revenue Service website: www.irs.gov**
- **Visit the State of California website: www.edd.ca.gov**

If you request a change, it will be put into effect within 60 days after receipt of the form.

Withholding is one way for you to pay a portion of your income tax. If no tax, or not enough tax, is withheld from your benefits, you may have to pay estimated taxes during the year or a tax penalty at the end of the year. Of course, *whether you have to pay state or federal income tax on your benefit payments depends on the total amount of your taxable income. Your decision on withholding is an important one, and you may wish to discuss it with a qualified tax adviser.*

Sincerely,
Boards of Trustees

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

May 13, 2022

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

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

RE: Temporary Changes to Retiree Coverage Eligibility Rules
Indemnity Plan Benefit Change for Over-the-Counter COVID tests

This Participant Notice advises you of material modifications made to your medical benefits. This information is important to you and your Dependents. Please take the time to read it carefully.

Temporary Change to Attachment Rule for Retiree Coverage

Recently some Participants that have qualified to begin receiving their pension from the Carpenters Pension Trust Fund for Northern California during the COVID-19 National Emergency period have been denied Retiree Health and Welfare due to a failure to satisfy the Plan's 'attachment rule'. The 'attachment rule' requires a Participant to have worked at least 300 hours in covered employment for a Contributing Employer, during which time contributions have been required to be paid into the Active Employees' Plan A, Plan B or Plan R, in each of the 2 calendar years immediately preceding the calendar year in which his/her pension effective date occurs which may be a challenge during the COVID-19 pandemic.

In order to accommodate this issue, the Trustees have decided to waive the recent attachment rule for retirees with over 30 years of service during the COVID-19 National Emergency.

Please note the waiver of this requirement is **a temporary change that will apply to initial qualifications for Retiree Health and Welfare coverage based on a service pension occurring during the National Emergency period declared on March 13, 2020 and renewed on February 18, 2022.**

Over-the-Counter (OTC) COVID-19 Tests

Carpenters Health and Welfare Trust Fund for California is required by federal law to cover certain OTC at-home COVID-19 tests purchased on or after January 15, 2022 through the end of the Public Health Emergency for eligible plan Participants with no cost sharing. **Note:** Tests purchased for employment purposes are not covered.

- Participants may purchase up to eight (8) COVID-19 tests per covered family member per month. Note: Tests performed at a doctor's office or hospital do not count toward the eight-test maximum for reimbursement.

- COVID-19 tests purchased from an Express Scripts In-Network Pharmacy or through the Express Scripts Mail Order Pharmacy will be covered at 100% with no copay, coinsurance or deductible.
- For tests purchased from out-of-network Pharmacies, you must submit a claim for reimbursement to ESI along with a copy of the receipt and the UPC code from your COVID-19 test's box. You'll be reimbursed for either the full cost of the test or $12—whichever amount is lower.

* * * * *

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 2022

To: All Active Participants and their Beneficiaries – Plan A and Plan R

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 $1,289/person ($2,578/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 1-800-810-2583 for a list of Contract providers outside the state of California.	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

Important Questions	Answers	Why This Matters:
		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	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Preventive care/screening/ Immunization	10% coinsurance	30% 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)	10% coinsurance	30% 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)	10% coinsurance	30% coinsurance	

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

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)	10% coinsurance	30% 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	10% coinsurance	30% 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:*** 10% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 30% coinsurance (10% 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	10% coinsurance	10% 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:*** 10% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 30% coinsurance (10% 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)	10% coinsurance	30% 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	10% coinsurance	30% 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: 10% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply	30% 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:*** 10% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply.	30% 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	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.
	Childbirth/delivery facility services	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Rehabilitation services	10% coinsurance	30% 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	10% coinsurance	30% 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	10% coinsurance	30% coinsurance	Rental covered up to reasonable purchase price.
	Hospice services	10% coinsurance	30% 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 ~~a~~$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

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

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.

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

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	$1,250
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$1,458

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	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$678

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	$270
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$408

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	$10 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs	$30 / prescription	Not Covered	Up to a 100-day supply retail and 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	20% 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	$50 / visit	$50 / 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)	No Charge	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	No Charge	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	No Charge	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: No Charge; Outpatient: $20 / visit	Not Covered	None
	Habilitation services	$20 / visit	Not Covered	None
	Skilled nursing care	No Charge	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 & 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	$0
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	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	$60

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	$0
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	$0
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.

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 2022

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	

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

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.

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

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

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

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.

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

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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 09/01/2022-08/31/2023

KAISER PERMANENTE®: Plan B and Flat Rate Plan

Coverage for: Individual / Family | Plan Type: HMO

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 & 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
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
www.carpenterfunds.com

July 2022

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 2022** is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

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
www.carpenterfunds.com

July 2022

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.

SPECIAL ENROLLMENT EVENT

IMPORTANT: Generally, you **will not** be allowed to change your benefit elections or add/delete dependents until next years' rolling enrollment period, unless you have a Special Enrollment Event or as outlined below:

- **Loss of Other Coverage Event**: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must **request enrollment within 31 days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).
- **Marriage, Birth, Adoption Event**: In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must **request enrollment within 31 days** after the marriage, birth, adoption, or placement for adoption.

Medicaid/CHIP Event: You and your eligible dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must **request enrollment within 60 days** after the Medicaid or CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must **request enrollment within 60 days** after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the Trust Fund Office.

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 are not 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, 2022. 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 Fax: 1-916-440-5676 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)
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	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/masshealth/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/Services/Assistance/Pages/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 and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.ww.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 1-304-558-1700 CHIP 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, 2022, 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, 2020 through August 31, 2021

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, 2020 through August 31, 2021. 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, 2021 were $293,341,241.

Basic Financial Statement:

The value of Plan assets, after subtracting liabilities of the Plan, was $795,724,450 minus premiums and self-funded claims payable of $74,292,391, minus claims incurred but not reported of $29,165,457, minus bank of hours liability of $157,715,000, equals $534,551,602 as of August 31, 2021, compared to $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 September 1, 2020. During the Plan year, the Plan experienced an increase in its net assets of $51,768,327. 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 9/01/2020 $482,783,275**	**As of 9/01/2019 $396,717,592**
Employer Contributions	$407,404,683	$434,869,382
Participant Contributions	$31,498,363	$31,417,512
Investments - Earnings	$40,208,384	$1,078,845
Sale of Assets - Earnings/Losses	$41,189,910	$43,619,115
Other Income	$20,172,879	$24,568,101
Plan Income	**$540,474,219**	**$535,552,955**
Insurance Premiums	$293,341,241	$288,691,387
Self-Funded Benefits	$179,995,596	$146,475,198
Administrative Fees	$13,711,927	$12,802,578
Investment Expenses	$1,657,128	$1,518,109
Total Expenses	**$488,705,892**	**$449,487,272**
Ending Balance Value of Net Plan Assets	**As of 08/31/2021 $534,551,602**	**As of 08/31/2020 $482,783,275**

During the plan year, the Plan had total income of $540,474,219; including employer contributions of $407,404,683, participant contributions of $31,498,363, realized gains of $41,189,910 from the sale of assets, earnings from investments of $40,208,384, and other income of $20,172,879.

Plan expenses were $488,705,892. These expenses included $13,711,927 in administrative expenses, $1,657,128 in investment expenses, $293,341,241 in premium costs, and $179,995,596 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.

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SUMMARY ANNUAL REPORT FOR
CARPENTERS ANNUITY TRUST FUND FOR NORTHERN CALIFORNIA

Plan Year – September 1, 2020 through August 31, 2021

This is a summary of the annual report for the Carpenters Annuity Trust Fund for Northern California, Employer Identification Number 94-6534591, for the period September 1, 2020 through August 31, 2021. The annual report has been filed with Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement:

Benefits under the Plan are provided by the Carpenters Annuity Trust Fund for Northern California. Plan expenses were $128,976,538. These expenses included $3.492.847 in administrative expenses, $7,441,888 in investment expenses, and $118,041,803 in benefits paid to participants and beneficiaries. A total of 64,733 persons were participants in or beneficiaries of the Plan at the end of the Plan year, although not all of these persons had yet earned the right to receive benefits.

The value of Plan assets, after subtracting liabilities of the Plan, was $3,156,392,867 as of August 31, 2021, compared to $2,744,317,137 as of September 1, 2020. During the Plan year, the Plan experienced an increase in its net assets of $412,075,730. This increase includes 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 09/01/2020 $2,744,317,137**	**As of 09/01/2019 $2,529,954,323**
Employer Contributions	$82,478,469	$87,918,617
Investments - Earnings	$379,642,252	$185,510,307
Sale of Assets – Earnings	$78,535,011	$47,073,140
Other Income	$396,536	$1,146,382
Plan Income	**$541,052,268**	**$321,648,446**
Merger of Assets to the Fund	$0	$1,334
Benefits Paid	$118,041,803	$97,159,858
Administrative Fees	$3,492,847	$3,810,602
Investment Expenses	$7,441,888	$6,316,506
Total Expenses	**$128,976,538**	**$107,286,966**
Ending Balance Value of Net Plan Assets	**As of 8/31/2021 $3,156,392,867**	**As of 8/31/2020 $2,744,317,137**

The Plan had total income of $541,052,268; including employer contributions of $82,478,469, a net gain of $78,535,011 from the sale of assets, earnings from investments of $379,642,252 and other income of $396,536.

Minimum Funding Standards:

Enough money was contributed to the plan to keep it funded in accordance with the minimum funding standards of ERISA.

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; 5. transactions in excess of 5 percent of the plan assets; 6. insurance information 7. information regarding any common or collective trusts and pooled separate accounts, in which the plan participates, and 8. actuarial information regarding the funding of the Plan.

Obtaining Copies of a Summary Annual Report:

The report provided is a summary of the annual report filed for the Carpenters Annuity Trust Fund for Northern 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.

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SUMMARY ANNUAL REPORT FOR
CARPENTERS VACATION, HOLIDAY, AND SICK LEAVE TRUST FUND FOR NORTHERN CALIFORNIA

Plan Year – September 1, 2020 through August 31, 2021

This is a summary of the annual report for the Carpenters Vacation, Holiday and Sick Leave Trust Fund for Northern California, Employer Identification Number 94-6276537, a multiemployer Vacation, Holiday, and Sick Leave Plan, for the period September 1, 2020 through August 31, 2021. 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 Vacation, Holiday and Sick Leave Trust Fund for Northern California has committed the Fund to pay all vacation, holiday, and sick leave benefits incurred under the terms of the Plan.

Basic Financial Statement:

The value of Plan assets, after subtracting liabilities of the Plan, was $11,900,732 as of August 31, 2021, compared to $8,462,170 as of September 1, 2020. During the Plan year, the Plan experienced an increase in its net assets of $3,438,562. 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.

During the plan year, the Plan had total income of $108,406,886; including employer contributions of $102,266,842, earnings (loss) from investments of ($531,634), net realized gains on the sale of assets of $5,875,477, and other income of $796,201.

Condensed Financial Statement		
Beginning Balance Value of Net Plan Assets	**As of 09/01/2020 $8,462,170**	**As of 09/01/2019 $9,525,943**
Employer Contributions	$102,266,842	$111,336,988
Investments – Earnings/ Losses	($531,634)	$1,747,713
Sale of Assets - Earnings/Losses	$5,875,477	($419,119)
Other Income	$796,201	$710,026
Plan Income	**$108,406,886**	**$113,375,608**
Benefits Paid	$102,804,367	$112,057,083
Administrative Fees	$2,154,537	$2,363,876
Investment Expenses	$9,420	$18,422
Total Expenses	**$104,968,324**	**$114,439,381**
Ending Balance Value of Net Plan Assets	**As of 08/31/2021 $11,900,732**	**As of 08/31/2020 $8,462,170**

Plan expenses were $104,968,324. These expenses included $2,154,537 in administrative expenses, $9,420 in investment expenses, and $102,804,367 in benefits paid to participants. A total of 31,379 persons were participants in or beneficiaries of the Plan at the end of the Plan year, although not all of these persons had yet earned the right to receive benefits at this time.

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 plan assets.

Obtaining Copies of a Summary Annual Report:

The report provided is a summary of the annual report filed for the Carpenters Vacation, Holiday and Sick Leave Trust Fund for Northern

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.

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SUMMARY ANNUAL REPORT FOR
NORTHERN CALIFORNIA CARPENTERS 401(K) TRUST FUND

Plan Year – September 1, 2020 through August 31, 2021

This is a summary of the annual report for the Northern California Carpenters 401(k) Trust Fund, Employer Identification Number 80-0204601, for the period September 1, 2020 through August 31, 2021. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement:

Benefits under the Plan are provided by the Northern California Carpenters 401(k) Trust Fund. Plan expenses were $9,890,733. These expenses included $379,258 in administrative expenses, $261,167 in investment expenses, and $9,250,308 in benefits paid to participants and beneficiaries. A total of 3,460 persons were participants in or beneficiaries of the Plan at the end of the Plan year, although not all of these persons had yet earned the right to receive benefits.

The value of Plan assets, after subtracting liabilities of the Plan, was $166,168,492 as of August 31, 2021, compared to $126,835,809 as of September 1, 2020. During the Plan year, the Plan experienced an increase in its net assets of $39,332,683. 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.

The Plan had total income of $49,223,416; including employee contributions of $18,162,686, employer contributions of $489,910, other contributions of $441,105, income from investments of $30,129,715 and other income of $0.

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. insurance information; and 6. information regarding any common or collective trusts in which the plan participates.

Obtaining Copies of a Summary Annual Report:

The report provided is a summary of the annual report filed for the Northern California Carpenters 401(k) Trust Fund. 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 Plan Administrator, at 265 Hegenberger

Condensed Financial Statement

Beginning Balance Value of Net Plan Assets	**As of 09/01/2020 $126,835,809**	**As of 09/01/2019 $98,534,502**
Participating Employee Contributions	$18,162,686	$17,292,061
Employer Contributions	$489,910	$582,360
Other Contributions	$441,105	$228,494
Investments – Earnings/Losses	$30,129,715	$19,625,375
Other Income	$0	$12,744
Plan Income	**$49,223,416**	**$37,741,034**
Benefits Paid	$9,250,308	$8,879,985
Administrative Fees	$379,258	$354,877
Investment Expenses	$261,167	$204,865
Total Expenses	**$9,890,733**	**$9,439,727**
Ending Balance Value of Net Plan Assets	**As of 08/31/2021 $166,168,492**	**As of 08/31/2020 $126,835,809**

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.

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CARPENTERS ANNUITY TRUST FUND FOR NORTHERN CALIFORNIA

(Enrollees of the Self Direct Investment Option)

and

NORTHERN CALIFORNIA CARPENTERS 401(K) TRUST FUND

Disclosure Document

As of March 31, 2022

This document includes important information to help you carefully compare the investment options available under your retirement Plan(s). To comply with federal regulations this information, which contains retirement plan fee information, is being distributed for **participant directed individual account plans**. *If you have not elected to self-direct investments in your Annuity Account or have not enrolled in the Northern California Carpenters 401(k) Plan, these investment options and fees do not apply.*

If you would like additional information about options to self-direct investments in your individual Carpenters Annuity Plan account or information regarding participation in the Northern California Carpenters 401(k) Plan, please contact John Hancock Retirement Plan Services or the Carpenter Funds Administrative Office - Benefit Services Department. For advisory help you may contact Pensionmark Retirement Services Group. Contact information is as follows:

John Hancock Retirement Plan Services ("John Hancock")
www.myplan.johnhancock.com or call (833) 388-6466 from 8:00 a.m. to 10:00 p.m. Eastern time on New York Stock Exchange business days

Carpenter Funds Administrative Office of Northern California ("Fund Office")
265 Hegenberger Road, Suite 100, Oakland, California 94621
www.carpenterfunds.com or call (888) 547-2054 or email: benefitservices@carpenterfunds.com

Pensionmark Financial Group ("Pensionmark")
www.pensionmark.com or call (888) 201-5488 from 8:30AM to 5:00PM Pacific Time.

Si tiene preguntas acerca de esta información, llame al 1(888) 440-0022. Los Agentes de servicio a los participantes están disponibles de 10:00 a.m. a 8 p.m. Hora del Este, todos los días hábiles de la Bolsa de Valores de Nueva York. Para protección suya, todas las llamadas a nuestros agentes son grabadas.

DOCUMENT SUMMARY

This document consists of performance information for the Carpenters Annuity and 401(k) Plans, investment options available, and information regarding how well the investments have performed in the past. It includes the fees and expenses you will pay if you invest in an option as well as Plan related information applicable to each Plan.

- **Carpenters Annuity Trust Fund for Northern California (Sections 1-3)**
- **Northern California Carpenters 401(k) Plan (Sections 4-6)**

Carpenters Annuity Trust Fund for Northern California
Section 1 – Performance Information

The information in this table focuses on the performance of investment options that do not have a fixed or stated rate of return. It shows how these investments have performed in the past and allows you to compare them with appropriate benchmarks for the same time periods. Information about an option's principal risks is available through the following website, myplan.johnhancock.com/investment_info. Please enter code "LO1505" to view your plan investment option details.

Total returns include changes in share price and reinvestment of all dividends and capital gains, if any, but not the effect of any sales charges, which are waived for qualified retirement plans. If sales charges were included, total returns would be lower.

For funds with redemption fees, performance shown does not reflect the deduction of this fee which would reduce performance.

Investment options are grouped according to investment objective. Within each investment objective grouping, funds are listed in alphabetical order. For more specific information, please refer to the investments' specific disclosure information.

Performance data quoted represents past performance. Past performance is no guarantee of future results. Due to market volatility, current performance may be less or higher than the figures shown. For the most recent month-end performance information, please log onto myplan.johnhancock.com or call a John Hancock representative at 833-388-6466.

Variable Rate Investments-Average Annual Total Returns (%)

INVESTMENT NAME/COMPARATIVE BENCHMARK	TICKER	1 MONTH	3 MONTH	YTD	1 YEAR	3 YEARS	5 YEARS	10 YEARS	SINCE INCEPTION	INCEPTION DATE
Income										
Janus Henderson Developed World Bond Fund (Class N)	HFARX	-2.99	-5.82	-5.82	-3.87	2.67	3.34	N/A	3.88	11/30/2015
BENCHMARK: Bloomberg Barclays Global Aggregate Bond Index (USD Hedged)[3]		-2.16	-4.97	-4.97	-3.92	1.30	2.25	2.84	2.42	
John Hancock Income Fund (Class R6) [2]	JSNWX	-0.94	-4.12	-4.12	-2.70	3.25	2.79	3.38	N/A	09/01/2011
BENCHMARK: Bloomberg Barclays US Aggregate Bond Index[20]		-2.78	-5.93	-5.93	-4.15	1.69	2.14	2.24	N/A	
PGIM High-Yield Fund (Class R6)	PHYQX	-1.40	-4.67	-4.67	0.03	5.18	5.26	6.02	N/A	10/31/2011
BENCHMARK: ICE BofA Merrill Lynch U.S. High Yield Index[26]		-0.93	-4.51	-4.51	-0.29	4.40	4.56	5.70	N/A	
Western Asset Core Plus Bond Fund (Class IS)	WAPSX	-3.79	-8.82	-8.82	-6.21	1.83	2.63	3.39	N/A	08/04/2008
BENCHMARK: Bloomberg Barclays US Aggregate Bond Index[20]		-2.78	-5.93	-5.93	-4.15	1.69	2.14	2.24	N/A	
Target Date										
The target date is the expected year in which participants in a Target Date Portfolio plan to retire and no longer make contributions. The investment strategy of these Portfolios are designed to become more conservative over time as the target date approaches (or if applicable passes) the target retirement date. The principal value of your investment as well as your potential rate of return, are not guaranteed at any time, including at or after the target retirement date. An investor should examine the asset allocation of the fund to ensure it is consistent with their own risk tolerance.										
Pensionmark Asset Allocation 2020		-0.86	-7.48	-7.48	-1.10	8.94	7.94	N/A	6.95	11/08/2012
BENCHMARK: Morningstar Lifetime Moderate 2020 Index[5]		-0.13	-5.67	-5.67	2.69	8.26	7.48	6.89	7.12	
Pensionmark Asset Allocation 2025		-0.22	-7.68	-7.68	-0.27	10.70	9.18	N/A	7.92	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2025 Index[6]		0.05	-5.93	-5.93	2.92	8.85	8.06	7.60	8.01	
Pensionmark Asset Allocation 2030		0.28	-8.03	-8.03	0.32	12.30	10.31	N/A	8.90	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2030 Index[7]		0.36	-5.98	-5.98	3.33	9.60	8.76	8.38	8.91	
Pensionmark Asset Allocation 2035		0.78	-8.22	-8.22	0.96	13.60	11.33	N/A	9.78	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2035 Index[8]		0.78	-5.83	-5.83	3.89	10.42	9.44	9.03	9.64	
Pensionmark Asset Allocation 2040		1.21	-8.62	-8.62	1.29	15.05	12.33	N/A	10.67	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2040 Index[9]		1.17	-5.60	-5.60	4.46	11.13	9.98	9.43	10.09	

Variable Rate Investments-Average Annual Total Returns (%)

INVESTMENT NAME/COMPARATIVE BENCHMARK	TICKER	1 MONTH	3 MONTH	YTD	1 YEAR	3 YEARS	5 YEARS	10 YEARS	SINCE INCEPTION	INCEPTION DATE
Pensionmark Asset Allocation 2045		1.44	-9.00	-9.00	1.14	15.85	12.94	N/A	11.36	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2045 Index[10]		1.43	-5.44	-5.44	4.80	11.54	10.25	9.56	10.24	
Pensionmark Asset Allocation 2050		1.45	-9.32	-9.32	0.96	16.26	13.27	N/A	11.08	02/01/2013
BENCHMARK: Morningstar Lifetime Moderate 2050 Index[11]		1.51	-5.38	-5.38	4.81	11.64	10.29	9.53	9.40	
Pensionmark Asset Allocation 2055		1.46	-9.31	-9.31	0.93	16.23	N/A	N/A	9.40	06/16/2017
BENCHMARK: Morningstar Lifetime Moderate 2050 Index[11]		1.51	-5.38	-5.38	4.81	11.64	10.29	9.53	9.99	
Pensionmark Asset Allocation 2060		1.44	-9.32	-9.32	0.97	16.27	12.74	N/A	12.97	04/18/2016
BENCHMARK: Morningstar Lifetime Moderate 2050 Index[11]		1.51	-5.38	-5.38	4.81	11.64	10.29	9.53	10.95	
Pensionmark Asset Allocation Income		-1.24	-7.11	-7.11	-1.31	7.60	6.95	N/A	5.73	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate Income Index[4]		-0.23	-4.14	-4.14	2.32	6.81	6.02	5.10	5.18	
Growth & Income										
American Funds - Washington Mutual Investors Fund (Class R6)	RWMGX	3.46	-1.89	-1.89	16.43	15.94	14.10	13.51	N/A	05/01/2009
BENCHMARK: S&P 500 Index[27]		3.71	-4.60	-4.60	15.65	18.92	15.99	14.64	N/A	
Cohen & Steers Real Estate Securities (Class Z)	CSZIX	6.72	-6.14	-6.14	23.59	13.97	11.96	N/A	12.48	10/01/2014
BENCHMARK: FTSE NAREIT All Equity Index[12]		7.07	-5.26	-5.26	23.58	11.72	10.69	10.51	10.68	
Columbia Dividend Income Fund (Institutional 3 Class)	CDDYX	3.51	-2.59	-2.59	13.05	15.04	13.44	N/A	13.82	11/08/2012
BENCHMARK: Russell 1000 Index[21]		3.37	-5.13	-5.13	13.27	18.71	15.82	14.53	15.50	
Vanguard 500 Index Fund (Admiral Shares)	VFIAX	3.70	-4.61	-4.61	15.60	18.89	15.95	14.60	N/A	11/13/2000
BENCHMARK: S&P 500 Index[27]		3.71	-4.60	-4.60	15.65	18.92	15.99	14.64	N/A	
Growth										
AB Large Cap Growth Fund (Class Z)	APGZX	1.59	-12.59	-12.59	11.48	20.60	20.07	N/A	17.16	06/30/2015
BENCHMARK: Russell 1000 Growth Index[15]		3.91	-9.04	-9.04	14.98	23.60	20.88	17.04	18.08	
Carillon Eagle Mid Cap Growth Fund (Class R6)	HRAUX	3.80	-10.40	-10.40	1.28	17.34	16.43	14.57	N/A	08/15/2011
BENCHMARK: Russell Midcap Growth Index[18]		1.61	-12.58	-12.58	-0.89	14.81	15.10	13.52	N/A	
Franklin Small Cap Value Fund (Class R6)	FRCSX	-1.15	-2.90	-2.90	1.86	13.84	9.91	N/A	10.66	05/01/2013
BENCHMARK: Russell 2000 Value Index[17]		1.96	-2.40	-2.40	3.32	12.73	8.57	10.54	9.83	
JPMorgan Small Cap Growth Fund (Class R6)	JGSMX	0.41	-13.84	-13.84	-17.75	13.24	16.83	14.36	N/A	11/30/2010
BENCHMARK: Russell 2000 Growth Index[16]		0.46	-12.63	-12.63	-14.33	9.88	10.33	11.21	N/A	
Janus Henderson Global Life Sciences Fund (Class I)	JFNIX	3.59	-5.22	-5.22	4.05	13.04	13.49	16.41	N/A	07/06/2009
BENCHMARK: S&P 500 Index[27]		3.71	-4.60	-4.60	15.65	18.92	15.99	14.64	N/A	
Vanguard Mid-Cap Index Fund (Admiral Shares)	VIMAX	2.69	-6.32	-6.32	8.82	15.67	13.00	12.94	N/A	11/12/2001
BENCHMARK: MSCI US Mid Cap 450 Index[24]		2.09	-5.74	-5.74	7.39	16.15	13.84	13.60	N/A	
Vanguard Small-Cap Index Fund (Admiral Shares)	VSMAX	1.48	-5.74	-5.74	0.68	13.16	11.34	12.11	N/A	11/13/2000
BENCHMARK: MSCI US Small Cap 1750 Index[25]		1.33	-5.69	-5.69	0.34	14.12	11.22	12.10	N/A	
Victory Sycamore Established Value Fund (Class I)	VEVIX	2.94	0.49	0.49	13.88	17.51	12.89	13.87	N/A	03/01/2010
BENCHMARK: Russell Midcap Value Index[19]		3.04	-1.82	-1.82	11.45	13.69	9.99	12.01	N/A	

Variable Rate Investments-Average Annual Total Returns (%)

INVESTMENT NAME/COMPARATIVE BENCHMARK	TICKER	1 MONTH	3 MONTH	YTD	1 YEAR	3 YEARS	5 YEARS	10 YEARS	SINCE INCEPTION	INCEPTION DATE
International										
American Funds - New World Fund (Class R6)	RNWGX	0.14	-10.34	-10.34	-6.50	9.91	9.86	7.13	N/A	05/01/2009
BENCHMARK: MSCI Emerging Markets Free Index[13]		-2.52	-7.32	-7.32	-13.27	2.57	3.56	0.92	N/A	
MFS International Intrinsic Value Fund (Class R6)	MINJX	-1.59	-13.07	-13.07	-2.07	9.23	9.57	10.09	N/A	05/01/2006
BENCHMARK: MSCI EAFE Index[22]		0.64	-5.91	-5.91	1.16	7.78	6.72	6.27	N/A	
T. Rowe Price Global Technology Fund (Class I)	PGTIX	-3.49	-25.40	-25.40	-18.31	17.05	17.08	N/A	18.98	11/29/2016
BENCHMARK: MSCI AC World Free Index[14]		1.94	-5.73	-5.73	5.68	11.85	9.65	7.88	10.70	
Vanguard International Growth Fund (Admiral Shares)	VWILX	-1.76	-16.45	-16.45	-16.21	14.87	14.11	10.48	N/A	08/13/2001
BENCHMARK: MSCI EAFE Index[22]		0.64	-5.91	-5.91	1.16	7.78	6.72	6.27	N/A	

Total returns are historical and include changes in share price and reinvestment of all dividends and capital gains, if any, but not the effect of any sales charges, which are waived for qualified retirement plans. If sales charges were included, total returns would be lower. Note - This Investment Return report is designed to provide investors with an illustration of the performance of only those funds and/or investments in the Plan's lineup as of the report date provided at the top of the first page. This report does not report performance figures for those funds and/or investments that were once in the Plan's lineup, and have since been removed from the lineup prior to the report date at the top of the first page. Further, the performance returns reported on this document represents performance for each respective fund; however, this does not represent the actual performance experience of individual participants within the Plan, due to participant's variability in cash flows, timing of cash flows, etc. For actual performance experience, participants should refer to the Personal rate of Return function online at mylife.jhrps.com, our Voice Response System (VRS), John Hancock participant service center, or periodic participant statements.

[2] In addition to fees charged by JHRPS for its services to the plan, affiliates of JHRPS receive investment management and other fees from the John Hancock Funds and other funds advised or sub-advised by JHRPS's affiliates.

[3] Bloomberg Barclays Global Aggregate Bond Index (USD Hedged) provides a broad based measure of the global investment-grade fixed-rate debt markets and covers the most liquid portion of the global investment grade fixed-rate bond market, including government, credit and collateralized securities. It is not possible to invest directly in an index.

[4] The Morningstar Lifetime Moderate Income Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target of moderate income. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[5] The Morningstar Lifetime Moderate 2020 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2020. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[6] The Morningstar Lifetime Moderate 2025 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2025. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[7] The Morningstar Lifetime Moderate 2030 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2030. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[8] The Morningstar Lifetime Moderate 2035 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2035. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[9] The Morningstar Lifetime Moderate 2040 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2040. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[10] The Morningstar Lifetime Moderate 2045 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2045. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[11] The Morningstar Lifetime Moderate 2050 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2050. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[12] FTSE NAREIT All Equity REITs Index: The National Association of Real Estate Investment Trusts (NAREIT) All Equity Index is an unmanaged market weighted index of tax qualified REITs listed on the New York Stock Exchange, American Stock Exchange and the NASDAQ National Market System, including dividends. An investment cannot be made directly into an index.

[13] MSCI Emerging Markets Free Index is an unmanaged index of a sample of companies representative of the market structure of 26 Emerging Markets countries. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[14] MSCI AC World Free Index is an unmanaged, market capitalization weighted index composed of companies representative of the market structure of 49 developed and emerging market countries. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[15] Russell 1000 Growth Index: The Russell 1000 Growth Index is an unmanaged index that measures the performance of those Russell 1000 companies with higher price-to-book ratios and higher forecasted growth values. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[16] Russell 2000 Growth Index: The Russell 2000 Growth Index is an unmanaged index that measures the performance of those Russell 2000 companies with higher price-to-book ratios and higher forecasted growth values. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[17] Russell 2000 Value Index: The Russell 2000 Value Index is an unmanaged index that measures the performance of those Russell 2000 companies with lower price-to-book ratios and lower forecasted growth values. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[18] Russell Midcap Growth Index: The Russell Midcap Growth Index is an unmanaged index that measures the performance of those Russell Midcap companies with higher price-to-book ratios and higher forecasted growth values. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[19] Russell Midcap Value Index: A market-weighted total return index that measures the performance of companies within the Russell Midcap Index having lower price-to-book ratios and lower forecasted growth values. The Russell Midcap Index includes firms 201 through 1000, based on market capitalization, from the Russell 3000 Index. The Russell 3000 Index represents 98% of the of the investable US equity market. An investment cannot be made directly into an index.

[20] Bloomberg Barclays US Aggregate Bond Index is an unmanaged market value-weighted performance benchmark for investment-grade or better fixed-rate debt issues, including government, corporate, asset-backed, and mortgage-backed securities, with maturities of at least one year. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[21] Russell 1000 Index: The Russell 1000 Index is an unmanaged index that measures the performance of the 1,000 largest companies in the Russell 3000 Index, which includes the 3,000 largest U.S. companies based on total market capitalization. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[22] MSCI EAFE Index: The MSCI EAFE Index (Europe, Australasia, Far East) is a free float-adjusted market capitalization index that is designed to measure the equity market performance of developed markets, excluding the US & Canada. The MSCI EAFE Index consists of the 22 developed market country indices in Europe, Australasia and the Far East. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[24] MSCI US Mid Cap 450 Index: The MSCI US Mid Cap 450 Index represents the universe of medium capitalization companies in the US equity market. This index targets for inclusion 450 companies and represents, as of October 29, 2004, approximately 15% of the capitalization of the US equity market. An investment cannot be made directly into an index.

[25] MSCI US Small Cap 1750 Index: The MSCI US Small Cap 1750 Index represents the universe of small capitalization companies in the US equity market. This index targets for inclusion 1,750 companies and represents, as of October 29, 2004, approximately 12% of the capitalization of the US equity market. An investment cannot be made directly into an index.

[26] BofA Merrill Lynch U.S. High Yield Master II Index is an unmanaged index which tracks the performance of below investment grade U.S. dollar-denominated corporate bonds publicly issued in the U.S. domestic market. An investment cannot be made directly into an index.

[27] S&P 500 Index is an unmanaged index and is widely regarded as the standard for measuring large-cap U.S. stock market performance. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

An investment cannot be made directly into an index.

The mutual fund performance and statistical data included here is supplied by Morningstar, Inc. and was collected from company reports, financial reporting services, periodicals and other sources believed to be reliable. Although carefully verified, data are not guaranteed by Morningstar, Inc. or John Hancock Retirement Plan Services, LLC.

The following information focuses on the performance of investment options that have a fixed or stated rate of return. This table shows the annual rate of return of each such option, the term or length of time that you will earn this rate of return, and other information relevant to performance.

Fixed Return Investments			
NAME/TYPE OF OPTION	**RETURNS**	**TERMS**	**OTHERS**
Stable Value			
NYL Guaranteed Interest Account[1] *myplan.johnhancock.com/investment_info*	2.25%	Semi-Annual	Rate credited through 06/30/2022

[1]This investment option is not a mutual fund.

Carpenters Annuity Trust Fund for Northern California
Section 2 – Fee and Expense Information

The following table shows fee and expense information for the plan's investment options. The Total Annual Operating Expenses are expenses that reduce the rates of return of the investment option. This table also shows any redemption fees charged by an investment option upon the sale or exchange of shares and the minimum number of days one must hold the investment in order to avoid a redemption fee.

Expense ratio (gross) does not include fee waivers or expense reimbursements which result in lower actual cost to the investor.

Fees and Expenses					
	TOTAL ANNUAL OPERATING EXPENSE		**REDEMPTION FEES**		
NAME/TYPE OF OPTION	**As a %**	**Per $1,000**	**%**	**# Days**	**Additional Information**
Stable Value					
NYL Guaranteed Interest Account	0.05%	$ 0.50	N/A	N/A	
Income					
Janus Henderson Developed World Bond Fund (Class N)	0.56%	$ 5.60	N/A	N/A	
John Hancock Income Fund (Class R6)	0.41%	$ 4.10	N/A	N/A	
PGIM High-Yield Fund (Class R6)	0.38%	$ 3.80	N/A	N/A	
Western Asset Core Plus Bond Fund (Class IS)	0.42%	$ 4.20	N/A	N/A	
Target Date					
Pensionmark Asset Allocation 2020	0.26%	$ 2.60	N/A	N/A	
Pensionmark Asset Allocation 2025	0.23%	$ 2.30	N/A	N/A	
Pensionmark Asset Allocation 2030	0.22%	$ 2.20	N/A	N/A	
Pensionmark Asset Allocation 2035	0.21%	$ 2.10	N/A	N/A	
Pensionmark Asset Allocation 2040	0.20%	$ 2.00	N/A	N/A	
Pensionmark Asset Allocation 2045	0.20%	$ 2.00	N/A	N/A	
Pensionmark Asset Allocation 2050	0.21%	$ 2.10	N/A	N/A	
Pensionmark Asset Allocation 2055	0.21%	$ 2.10	N/A	N/A	
Pensionmark Asset Allocation 2060	0.21%	$ 2.10	N/A	N/A	
Pensionmark Asset Allocation Income	0.26%	$ 2.60	N/A	N/A	
Growth & Income					
American Funds - Washington Mutual Investors Fund (Class R6)	0.27%	$ 2.70	N/A	N/A	

Fees and Expenses					
	TOTAL ANNUAL OPERATING EXPENSE		REDEMPTION FEES		
NAME/TYPE OF OPTION	As a %	Per $1,000	%	# Days	Additional Information
Cohen & Steers Real Estate Securities (Class Z)	0.78%	$ 7.80	N/A	N/A	
Columbia Dividend Income Fund (Institutional 3 Class)	0.56%	$ 5.60	N/A	N/A	
Vanguard 500 Index Fund (Admiral Shares)	0.04%	$ 0.40	N/A	N/A	
Growth					
AB Large Cap Growth Fund (Class Z)	0.53%	$ 5.30	N/A	N/A	
Carillon Eagle Mid Cap Growth Fund (Class R6)	0.63%	$ 6.30	N/A	N/A	
Franklin Small Cap Value Fund (Class R6)	0.69%	$ 6.90	N/A	N/A	
JPMorgan Small Cap Growth Fund (Class R6)	0.74%	$ 7.40	N/A	N/A	
Janus Henderson Global Life Sciences Fund (Class I)	0.75%	$ 7.50	N/A	N/A	
Vanguard Mid-Cap Index Fund (Admiral Shares)	0.05%	$ 0.50	N/A	N/A	
Vanguard Small-Cap Index Fund (Admiral Shares)	0.05%	$ 0.50	N/A	N/A	
Victory Sycamore Established Value Fund (Class I)	0.58%	$ 5.80	N/A	N/A	
International					
American Funds - New World Fund (Class R6)	0.57%	$ 5.70	N/A	N/A	
MFS International Intrinsic Value Fund (Class R6)	0.62%	$ 6.20	N/A	N/A	
T. Rowe Price Global Technology Fund (Class I)	0.75%	$ 7.50	N/A	N/A	
Vanguard International Growth Fund (Admiral Shares)	0.32%	$ 3.20	N/A	N/A	

The cumulative effect of fees and expenses can substantially reduce the growth of your retirement savings. Visit the Department of Labor's Web site for an example showing the long-term effect of fees and expenses at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/pension-protection-act/investing-and-diversification. Fees and expenses are only one of many factors to consider when you decide to invest in an option. You may also want to think about whether an investment in a particular option, along with your other investments, will help you achieve your financial goals.

Please visit myplan.johnhancock.com for a glossary of investment terms relevant to this plan. The glossary is intended to help you better understand your options.

Carpenters Annuity Trust Fund for Northern California
Section 3 – Plan Related Information

PLAN ADMINISTRATIVE EXPENSES

Participant Directed: In addition to the total annual operating fees associated with the investments, an annual pro-rata administrative fee of approximately 0.28% will be deducted from participant accounts on a monthly basis. As an example: For an account balance of $50,000 the monthly pro-rata fee would be approximately $11.67. In addition, participants in the Plan pay a quarterly fixed administrative fee. As an example, for the last four quarters ending February 28, 2022, the fixed administrative fee was on average $14.75 per quarter.

The Carpenters Annuity Plan may pay outside service providers for administrative services rendered during the year, such as recordkeeping and investment advisory services. Such amounts may be paid from a segregated account under the Annuity Plan and/or may be charged against participants' accounts on a pro-rata basis in accordance with the Amended and Restated Rules and Regulations of the Plan. Any amounts assessed against your account will be disclosed on a quarterly basis.

PARTICIPANT EXPENSES

To ensure that you receive your benefits when eligible, the Trustees of the Carpenters Annuity Trust Fund Trust Fund have a policy in place to locate and pay benefits to unenrolled and missing Participants or Beneficiaries of the Plan. The process of enrolling or locating missing Participants or Beneficiaries can include multiple efforts depending on the amount of the unpaid account balance and how long it takes to locate the individual. Each attempt made to contact such individuals will result in a fee assessment. The costs associated with location services may be revised from time-to-time, and currently include:

Participant Notice	$6.86	Separation from Service Invalid Address Union Notice	$5.28
Employer Notice	$5.38	Separation from Service Invalid Address Locator Service	$5.23
Union Notice	$5.28	Separation from Service Follow Up Letter	$5.23
Un-enrolled or Invalid Address Locator Service	$5.23	Frozen Account Locator Service	$5.23
Un-cashed Check(s) Letter	$9.16	Frozen Account Reinstatement	$0.06
Un-cashed Check(s) Locator Service	$13.48	Separation from Service Invalid Address Second Follow Up	$5.24
		Required Minimum Distribution Locator Service	$5.39

To avoid an assessment for location efforts, simply keep the Fund Office apprised of your current address and if you have not yet done so, complete an enrollment form which can be downloaded from the website, www.carpenterfunds.com, fill it out and mail or fax it to the Carpenter Fund Office. You can also obtain a form by calling the Fund Office at (888) 547- 2054.

ACCESS TO INFORMATION

As a participant in the plan, you have the right to request paper copies, free of charge, of any information required to be available on the plan website. This includes past and current statements. To request this, you can contact a John Hancock participant service representative at 833-388-6466 from 08:00 a.m. to 10:00 p.m. Eastern time on New York Stock Exchange business days. For your protection, all calls to our representatives are recorded. In addition, your past and current statements are available through our secure website at mylife.jhrps.com/statements.

ABILITY TO DIRECT INVESTMENTS

"Qualified" Participants have the option of selecting their own investment options from a select group of mutual funds. In order to become a qualified Participant, you must participate in a special education program to learn more about selecting your own investment options. Once qualified, you have the right to transfer into or out of any investment option in your Carpenters Annuity Plan at any time. Investment options in your Annuity Plan may have implemented restrictions such as short-term trading fees and/or trading blackout periods on certain transactions. If these apply to any of the options in the Annuity Plan, they will be explained in the Fees and Expenses section. Mutual funds are not appropriate for frequent trading and most mutual funds monitor and restrict such activity. If you conduct transactions in a particular fund too often or attempt to exchange among related funds soon after purchasing, the mutual fund may restrict or deny future purchases. The plan's named fiduciary, or its delegate, exercises voting, tender and any similar rights associated with the plan's designated investment alternatives. To change any of your investments, you can go to myplan.johnhancock.com at any time, or you can call John Hancock at 1(833) 388-6466 from 8:00 a.m. to 10:00 p.m. Eastern time on New York Stock Exchange business days. For your protection, all calls to a John Hancock Representative are recorded.

RESTRICTED INVESTMENTS

The following funds have restrictions as described below:

1) Trustee Directed Option: This investment may have restrictions regarding contributions and liquidations. Allocations in this investment may be limited to 0% of your account balance.

Mutual funds are not appropriate for frequent trading and most mutual funds monitor and restrict such activity. If you conduct transactions in a particular fund too often or attempt to exchange among related funds soon after purchasing, the mutual fund may restrict or deny future purchases. Please review the funds' prospectuses for more information.

ABOUT RISK

All investing involves risk. It is possible that your investment objectives may not be met. All mutual funds are subject to market risk and may fluctuate in value.

Neither John Hancock Retirement Plan Services, LLC, its affiliates nor its representatives provide tax, legal or accounting advice. Please contact your own advisors.

Please contact John Hancock at 833-388-6466 for a prospectus, and, if available, a summary prospectus. Investors are asked to consider the investment objectives, risks, and charges and expenses of the investment carefully before investing. The prospectus or summary prospectus, contains this and other information about the investment company. Please read this information carefully before investing.

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. Las horas de oficina son de 8:00 a.m. a 5:00 p.m., lunes a viernes. Usted también puede llamar a la oficina del Plan, teléfono 888-547-2054, para ayuda.

Northern California Carpenters 401(k) Trust Fund
Section 4 – Performance Information

The information in this table focuses on the performance of investment options that do not have a fixed or stated rate of return. It shows how these investments have performed in the past and allows you to compare them with appropriate benchmarks for the same time periods. Information about an option's principal risks is available through the following website, myplan.johnhancock.com/investment_info. Please enter code "LO1502" to view your plan investment option details.

Total returns include changes in share price and reinvestment of all dividends and capital gains, if any, but not the effect of any sales charges, which are waived for qualified retirement plans. If sales charges were included, total returns would be lower.

For funds with redemption fees, performance shown does not reflect the deduction of this fee which would reduce performance.

Investment options are grouped according to investment objective. Within each investment objective grouping, funds are listed in alphabetical order. For more specific information, please refer to the investments' specific disclosure information.

Performance data quoted represents past performance. Past performance is no guarantee of future results. Due to market volatility, current performance may be less or higher than the figures shown. For the most recent month-end performance information, please log onto myplan.johnhancock.com or call a John Hancock representative at 833-388-6466.

Variable Rate Investments-Average Annual Total Returns (%)

INVESTMENT NAME/COMPARATIVE BENCHMARK	TICKER	1 MONTH	3 MONTH	YTD	1 YEAR	3 YEARS	5 YEARS	10 YEARS	SINCE INCEPTION	INCEPTION DATE
Income										
Janus Henderson Developed World Bond Fund (Class N)	HFARX	-2.99	-5.82	-5.82	-3.87	2.67	3.34	N/A	3.88	11/30/2015
BENCHMARK: Bloomberg Barclays Global Aggregate Bond Index (USD Hedged)[4]		-2.16	-4.97	-4.97	-3.92	1.30	2.25	2.84	2.42	
John Hancock Income Fund (Class R6) [2]	JSNWX	-0.94	-4.12	-4.12	-2.70	3.25	2.79	3.38	N/A	09/01/2011
BENCHMARK: Bloomberg Barclays US Aggregate Bond Index[22]		-2.78	-5.93	-5.93	-4.15	1.69	2.14	2.24	N/A	
PGIM High-Yield Fund (Class R6)	PHYQX	-1.40	-4.67	-4.67	0.03	5.18	5.26	6.02	N/A	10/31/2011
BENCHMARK: ICE BofA Merrill Lynch U.S. High Yield Index[28]		-0.93	-4.51	-4.51	-0.29	4.40	4.56	5.70	N/A	
Western Asset Core Plus Bond Fund (Class IS)	WAPSX	-3.79	-8.82	-8.82	-6.21	1.83	2.63	3.39	N/A	08/04/2008
BENCHMARK: Bloomberg Barclays US Aggregate Bond Index[22]		-2.78	-5.93	-5.93	-4.15	1.69	2.14	2.24	N/A	
Asset Allocation										
New Northern California Carpenter Allocation Option		1.38	-5.09	-5.09	6.58	N/A	N/A	N/A	8.65	12/28/2020
BENCHMARK: Morningstar Moderate Target Risk Index[5]		0.07	-5.19	-5.19	2.26	8.88	8.02	7.35	4.23	
Target Date										
The target date is the expected year in which participants in a Target Date Portfolio plan to retire and no longer make contributions. The investment strategy of these Portfolios are designed to become more conservative over time as the target date approaches (or if applicable passes) the target retirement date. The principal value of your investment as well as your potential rate of return, are not guaranteed at any time, including at or after the target retirement date. An investor should examine the asset allocation of the fund to ensure it is consistent with their own risk tolerance.										
Pensionmark Asset Allocation 2020		-0.85	-7.48	-7.48	-1.09	8.91	7.92	N/A	6.92	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2020 Index[7]		-0.13	-5.67	-5.67	2.69	8.26	7.48	6.89	7.18	
Pensionmark Asset Allocation 2025		-0.23	-7.68	-7.68	-0.30	10.72	9.18	N/A	7.95	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2025 Index[8]		0.05	-5.93	-5.93	2.92	8.85	8.06	7.60	8.01	
Pensionmark Asset Allocation 2030		0.29	-8.03	-8.03	0.31	12.29	10.31	N/A	8.88	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2030 Index[9]		0.36	-5.98	-5.98	3.33	9.60	8.76	8.38	8.91	

Variable Rate Investments-Average Annual Total Returns (%)

INVESTMENT NAME/COMPARATIVE BENCHMARK	TICKER	1 MONTH	3 MONTH	YTD	1 YEAR	3 YEARS	5 YEARS	10 YEARS	SINCE INCEPTION	INCEPTION DATE
Pensionmark Asset Allocation 2035		0.78	-8.21	-8.21	0.97	13.62	11.32	N/A	9.80	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2035 Index[10]		0.78	-5.83	-5.83	3.89	10.42	9.44	9.03	9.64	
Pensionmark Asset Allocation 2040		1.21	-8.62	-8.62	1.29	15.08	12.35	N/A	10.72	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2040 Index[11]		1.17	-5.60	-5.60	4.46	11.13	9.98	9.43	10.09	
Pensionmark Asset Allocation 2045		1.41	-9.02	-9.02	1.11	15.85	12.93	N/A	11.38	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2045 Index[12]		1.43	-5.44	-5.44	4.80	11.54	10.25	9.56	10.24	
Pensionmark Asset Allocation 2050		1.45	-9.32	-9.32	0.96	16.25	13.26	N/A	11.91	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate 2050 Index[13]		1.51	-5.38	-5.38	4.81	11.64	10.29	9.53	10.21	
Pensionmark Asset Allocation 2055		1.45	-9.32	-9.32	0.95	16.26	13.40	N/A	11.56	06/10/2015
BENCHMARK: Morningstar Lifetime Moderate 2050 Index[13]		1.51	-5.38	-5.38	4.81	11.64	10.29	9.53	8.97	
Pensionmark Asset Allocation 2060		1.45	-9.32	-9.32	0.94	16.25	13.53	N/A	12.01	08/10/2015
BENCHMARK: Morningstar Lifetime Moderate 2050 Index[13]		1.51	-5.38	-5.38	4.81	11.64	10.29	9.53	9.47	
Pensionmark Asset Allocation Income		-1.24	-7.11	-7.11	-1.32	7.61	6.96	N/A	5.74	11/09/2012
BENCHMARK: Morningstar Lifetime Moderate Income Index[6]		-0.23	-4.14	-4.14	2.32	6.81	6.02	5.10	5.18	
Growth & Income										
American Funds - Washington Mutual Investors Fund (Class R6)	RWMGX	3.46	-1.89	-1.89	16.43	15.94	14.10	13.51	N/A	05/01/2009
BENCHMARK: S&P 500 Index[29]		3.71	-4.60	-4.60	15.65	18.92	15.99	14.64	N/A	
Cohen & Steers Real Estate Securities (Class Z)	CSZIX	6.72	-6.14	-6.14	23.59	13.97	11.96	N/A	12.48	10/01/2014
BENCHMARK: FTSE NAREIT All Equity Index[14]		7.07	-5.26	-5.26	23.58	11.72	10.69	10.51	10.68	
Columbia Dividend Income Fund (Institutional 3 Class)	CDDYX	3.51	-2.59	-2.59	13.05	15.04	13.44	N/A	13.82	11/08/2012
BENCHMARK: Russell 1000 Index[23]		3.37	-5.13	-5.13	13.27	18.71	15.82	14.53	15.50	
Vanguard 500 Index Fund (Admiral Shares)	VFIAX	3.70	-4.61	-4.61	15.60	18.89	15.95	14.60	N/A	11/13/2000
BENCHMARK: S&P 500 Index[29]		3.71	-4.60	-4.60	15.65	18.92	15.99	14.64	N/A	
Growth										
AB Large Cap Growth Fund (Class Z)	APGZX	1.59	-12.59	-12.59	11.48	20.60	20.07	N/A	17.16	06/30/2015
BENCHMARK: Russell 1000 Growth Index[17]		3.91	-9.04	-9.04	14.98	23.60	20.88	17.04	18.08	
Carillon Eagle Mid Cap Growth Fund (Class R6)	HRAUX	3.80	-10.40	-10.40	1.28	17.34	16.43	14.57	N/A	08/15/2011
BENCHMARK: Russell Midcap Growth Index[20]		1.61	-12.58	-12.58	-0.89	14.81	15.10	13.52	N/A	
Franklin Small Cap Value Fund (Class R6)	FRCSX	-1.15	-2.90	-2.90	1.86	13.84	9.91	N/A	10.66	05/01/2013
BENCHMARK: Russell 2000 Value Index[19]		1.96	-2.40	-2.40	3.32	12.73	8.57	10.54	9.83	
JPMorgan Small Cap Growth Fund (Class R6)	JGSMX	0.41	-13.84	-13.84	-17.75	13.24	16.83	14.36	N/A	11/30/2010
BENCHMARK: Russell 2000 Growth Index[18]		0.46	-12.63	-12.63	-14.33	9.88	10.33	11.21	N/A	
Janus Henderson Global Life Sciences Fund (Class I)	JFNIX	3.59	-5.22	-5.22	4.05	13.04	13.49	16.41	N/A	07/06/2009
BENCHMARK: S&P 500 Index[29]		3.71	-4.60	-4.60	15.65	18.92	15.99	14.64	N/A	
Vanguard Mid-Cap Index Fund (Admiral Shares)	VIMAX	2.69	-6.32	-6.32	8.82	15.67	13.00	12.94	N/A	11/12/2001
BENCHMARK: MSCI US Mid Cap 450 Index[26]		2.09	-5.74	-5.74	7.39	16.15	13.84	13.60	N/A	

Variable Rate Investments-Average Annual Total Returns (%)

INVESTMENT NAME/COMPARATIVE BENCHMARK	TICKER	1 MONTH	3 MONTH	YTD	1 YEAR	3 YEARS	5 YEARS	10 YEARS	SINCE INCEPTION	INCEPTION DATE
Vanguard Small-Cap Index Fund (Admiral Shares)	VSMAX	1.48	-5.74	-5.74	0.68	13.16	11.34	12.11	N/A	11/13/2000
BENCHMARK: MSCI US Small Cap 1750 Index[27]		1.33	-5.69	-5.69	0.34	14.12	11.22	12.10	N/A	
Victory Sycamore Established Value Fund (Class I)	VEVIX	2.94	0.49	0.49	13.88	17.51	12.89	13.87	N/A	03/01/2010
BENCHMARK: Russell Midcap Value Index[21]		3.04	-1.82	-1.82	11.45	13.69	9.99	12.01	N/A	
International										
American Funds - New World Fund (Class R6)	RNWGX	0.14	-10.34	-10.34	-6.50	9.91	9.86	7.13	N/A	05/01/2009
BENCHMARK: MSCI Emerging Markets Free Index[15]		-2.52	-7.32	-7.32	-13.27	2.57	3.56	0.92	N/A	
MFS International Intrinsic Value Fund (Class R6)	MINJX	-1.59	-13.07	-13.07	-2.07	9.23	9.57	10.09	N/A	05/01/2006
BENCHMARK: MSCI EAFE Index[24]		0.64	-5.91	-5.91	1.16	7.78	6.72	6.27	N/A	
T. Rowe Price Global Technology Fund (Class I)	PGTIX	-3.49	-25.40	-25.40	-18.31	17.05	17.08	N/A	18.98	11/29/2016
BENCHMARK: MSCI AC World Free Index[16]		1.94	-5.73	-5.73	5.68	11.85	9.65	7.88	10.70	
Vanguard International Growth Fund (Admiral Shares)	VWILX	-1.76	-16.45	-16.45	-16.21	14.87	14.11	10.48	N/A	08/13/2001
BENCHMARK: MSCI EAFE Index[24]		0.64	-5.91	-5.91	1.16	7.78	6.72	6.27	N/A	

Total returns are historical and include changes in share price and reinvestment of all dividends and capital gains, if any, but not the effect of any sales charges, which are waived for qualified retirement plans. If sales charges were included, total returns would be lower. Note - This Investment Return report is designed to provide investors with an illustration of the performance of only those funds and/or investments in the Plan's lineup as of the report date provided at the top of the first page. This report does not report performance figures for those funds and/or investments that were once in the Plan's lineup, and have since been removed from the lineup prior to the report date at the top of the first page. Further, the performance returns reported on this document represents performance for each respective fund; however, this does not represent the actual performance experience of individual participants within the Plan, due to participant's variability in cash flows, timing of cash flows, etc. For actual performance experience, participants should refer to the Personal rate of Return function online at mylife.jhrps.com, our Voice Response System (VRS), John Hancock participant service center, or periodic participant statements.

[2] In addition to fees charged by JHRPS for its services to the plan, affiliates of JHRPS receive investment management and other fees from the John Hancock Funds and other funds advised or sub-advised by JHRPS's affiliates.

[4] Bloomberg Barclays Global Aggregate Bond Index (USD Hedged) provides a broad based measure of the global investment-grade fixed-rate debt markets and covers the most liquid portion of the global investment grade fixed-rate bond market, including government, credit and collateralized securities. It is not possible to invest directly in an index.

[5] The Morningstar Moderate Index represents a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in a static allocation appropriate for U.S. investors who seek average exposure to equity market risk and returns. An investment cannot be made directly into an index.

[6] The Morningstar Lifetime Moderate Income Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target of moderate income. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[7] The Morningstar Lifetime Moderate 2020 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2020. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[8] The Morningstar Lifetime Moderate 2025 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2025. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[9] The Morningstar Lifetime Moderate 2030 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2030. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[10] The Morningstar Lifetime Moderate 2035 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2035. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[11] The Morningstar Lifetime Moderate 2040 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2040. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[12] The Morningstar Lifetime Moderate 2045 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2045. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[13] The Morningstar Lifetime Moderate 2050 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a target maturity date of 2050. The Moderate risk profile is for investors who are comfortable with average exposure to equity market volatility. An investment cannot be made directly into an index.

[14] FTSE NAREIT All Equity REITs Index: The National Association of Real Estate Investment Trusts (NAREIT) All Equity Index is an unmanaged market weighted index of tax qualified REITs listed on the New York Stock Exchange, American Stock Exchange and the NASDAQ National Market System, including dividends. An investment cannot be made directly into an index.

[15] MSCI Emerging Markets Free Index is an unmanaged index of a sample of companies representative of the market structure of 26 Emerging Markets countries. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[16] MSCI AC World Free Index is an unmanaged, market capitalization weighted index composed of companies representative of the market structure of 49 developed and emerging market countries. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[17] Russell 1000 Growth Index: The Russell 1000 Growth Index is an unmanaged index that measures the performance of those Russell 1000 companies with higher price-to-book ratios and higher forecasted growth values. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[18] Russell 2000 Growth Index: The Russell 2000 Growth Index is an unmanaged index that measures the performance of those Russell 2000 companies with higher price-to-book ratios and higher forecasted growth values. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[19] Russell 2000 Value Index: The Russell 2000 Value Index is an unmanaged index that measures the performance of those Russell 2000 companies with lower price-to-book ratios and lower forecasted growth values. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[20] Russell Midcap Growth Index: The Russell Midcap Growth Index is an unmanaged index that measures the performance of those Russell Midcap companies with higher price-to-book ratios and higher forecasted growth values. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[21] Russell Midcap Value Index: A market-weighted total return index that measures the performance of companies within the Russell Midcap Index having lower price-to-book ratios and lower forecasted growth values. The Russell Midcap Index includes firms 201 through 1000, based on market capitalization, from the Russell 3000 Index. The Russell 3000 Index represents 98% of the of the investable US equity market. An investment cannot be made directly into an index.

[22] Bloomberg Barclays US Aggregate Bond Index is an unmanaged market value-weighted performance benchmark for investment-grade or better fixed-rate debt issues, including government, corporate, asset-backed, and mortgage-backed securities, with maturities of at least one year. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[23] Russell 1000 Index: The Russell 1000 Index is an unmanaged index that measures the performance of the 1,000 largest companies in the Russell 3000 Index, which includes the 3,000 largest U.S. companies based on total market capitalization. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[24] MSCI EAFE Index: The MSCI EAFE Index (Europe, Australasia, Far East) is a free float-adjusted market capitalization index that is designed to measure the equity market performance of developed markets, excluding the US & Canada. The MSCI EAFE Index consists of the 22 developed market country indices in Europe, Australasia and the Far East. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

[26] MSCI US Mid Cap 450 Index: The MSCI US Mid Cap 450 Index represents the universe of medium capitalization companies in the US equity market. This index targets for inclusion 450 companies and represents, as of October 29, 2004, approximately 15% of the capitalization of the US equity market. An investment cannot be made directly into an index.

[27] MSCI US Small Cap 1750 Index: The MSCI US Small Cap 1750 Index represents the universe of small capitalization companies in the US equity market. This index targets for inclusion 1,750 companies and represents, as of October 29, 2004, approximately 12% of the capitalization of the US equity market. An investment cannot be made directly into an index.

[28] BofA Merrill Lynch U.S. High Yield Master II Index is an unmanaged index which tracks the performance of below investment grade U.S. dollar-denominated corporate bonds publicly issued in the U.S. domestic market. An investment cannot be made directly into an index.

[29] S&P 500 Index is an unmanaged index and is widely regarded as the standard for measuring large-cap U.S. stock market performance. Results assume the reinvestment of all capital gain and dividend distributions. An investment cannot be made directly into an index.

An investment cannot be made directly into an index.

The mutual fund performance and statistical data included here is supplied by Morningstar, Inc. and was collected from company reports, financial reporting services, periodicals and other sources believed to be reliable. Although carefully verified, data are not guaranteed by Morningstar, Inc. or John Hancock Retirement Plan Services, LLC.

The following information focuses on the performance of investment options that have a fixed or stated rate of return. This table shows the annual rate of return of each such option, the term or length of time that you will earn this rate of return, and other information relevant to performance.

Fixed Return Investments

NAME/TYPE OF OPTION	RETURNS	TERMS	OTHERS
Stable Value			
NYL Guaranteed Interest Account[1] *myplan.johnhancock.com/investment_info*	2.25%	Semi-Annual	Rate credited through 06/30/2022

[1] This investment option is not a mutual fund.

Northern California Carpenters 401(k) Trust Fund
Section 5 – Fee and Expense Information

The following table shows fee and expense information for the plan's investment options. The Total Annual Operating Expenses are expenses that reduce the rates of return of the investment option. This table also shows any redemption fees charged by an investment option upon the sale or exchange of shares and the minimum number of days one must hold the investment in order to avoid a redemption fee.

Expense ratio (gross) does not include fee waivers or expense reimbursements which result in lower actual cost to the investor.

Fees and Expenses

	TOTAL ANNUAL OPERATING EXPENSE		REDEMPTION FEES		
NAME/TYPE OF OPTION	As a %	Per $1,000	%	# Days	Additional Information
Stable Value					
NYL Guaranteed Interest Account	0.05%	$ 0.50	N/A	N/A	
Income					
Janus Henderson Developed World Bond Fund (Class N)	0.56%	$ 5.60	N/A	N/A	
John Hancock Income Fund (Class R6)	0.41%	$ 4.10	N/A	N/A	
PGIM High-Yield Fund (Class R6)	0.38%	$ 3.80	N/A	N/A	
Western Asset Core Plus Bond Fund (Class IS)	0.42%	$ 4.20	N/A	N/A	
Asset Allocation					
New Northern California Carpenter Allocation Option	0.59%	$ 5.90	N/A	N/A	
Target Date					
Pensionmark Asset Allocation 2020	0.26%	$ 2.60	N/A	N/A	
Pensionmark Asset Allocation 2025	0.23%	$ 2.30	N/A	N/A	
Pensionmark Asset Allocation 2030	0.23%	$ 2.30	N/A	N/A	
Pensionmark Asset Allocation 2035	0.21%	$ 2.10	N/A	N/A	
Pensionmark Asset Allocation 2040	0.20%	$ 2.00	N/A	N/A	
Pensionmark Asset Allocation 2045	0.20%	$ 2.00	N/A	N/A	
Pensionmark Asset Allocation 2050	0.21%	$ 2.10	N/A	N/A	
Pensionmark Asset Allocation 2055	0.21%	$ 2.10	N/A	N/A	

Fees and Expenses					
	TOTAL ANNUAL OPERATING EXPENSE		REDEMPTION FEES		
NAME/TYPE OF OPTION	As a %	Per $1,000	%	# Days	Additional Information
Pensionmark Asset Allocation 2060	0.21%	$ 2.10	N/A	N/A	
Pensionmark Asset Allocation Income	0.26%	$ 2.60	N/A	N/A	
Growth & Income					
American Funds - Washington Mutual Investors Fund (Class R6)	0.27%	$ 2.70	N/A	N/A	
Cohen & Steers Real Estate Securities (Class Z)	0.78%	$ 7.80	N/A	N/A	
Columbia Dividend Income Fund (Institutional 3 Class)	0.56%	$ 5.60	N/A	N/A	
Vanguard 500 Index Fund (Admiral Shares)	0.04%	$ 0.40	N/A	N/A	
Growth					
AB Large Cap Growth Fund (Class Z)	0.53%	$ 5.30	N/A	N/A	
Carillon Eagle Mid Cap Growth Fund (Class R6)	0.63%	$ 6.30	N/A	N/A	
Franklin Small Cap Value Fund (Class R6)	0.69%	$ 6.90	N/A	N/A	
JPMorgan Small Cap Growth Fund (Class R6)	0.74%	$ 7.40	N/A	N/A	
Janus Henderson Global Life Sciences Fund (Class I)	0.75%	$ 7.50	N/A	N/A	
Vanguard Mid-Cap Index Fund (Admiral Shares)	0.05%	$ 0.50	N/A	N/A	
Vanguard Small-Cap Index Fund (Admiral Shares)	0.05%	$ 0.50	N/A	N/A	
Victory Sycamore Established Value Fund (Class I)	0.58%	$ 5.80	N/A	N/A	
International					
American Funds - New World Fund (Class R6)	0.57%	$ 5.70	N/A	N/A	
MFS International Intrinsic Value Fund (Class R6)	0.62%	$ 6.20	N/A	N/A	
T. Rowe Price Global Technology Fund (Class I)	0.75%	$ 7.50	N/A	N/A	
Vanguard International Growth Fund (Admiral Shares)	0.32%	$ 3.20	N/A	N/A	

The cumulative effect of fees and expenses can substantially reduce the growth of your retirement savings. Visit the Department of Labor's Web site for an example showing the long-term effect of fees and expenses at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/pension-protection-act/investing-and-diversification. Fees and expenses are only one of many factors to consider when you decide to invest in an option. You may also want to think about whether an investment in a particular option, along with your other investments, will help you achieve your financial goals.

Please visit myplan.johnhancock.com for a glossary of investment terms relevant to this plan. The glossary is intended to help you better understand your options.

Northern California Carpenters 401(k) Trust Fund
Section 6 – Plan Related Information

PLAN ADMINISTRATIVE EXPENSES

In addition to the total annual operating fees associated with the investments, an annual administrative fee of approximately 0.30% will be paid by each participant. The fee is deducted from individual account balances on a pro-rata basis each month. As an example, if you have an account balance of $50,000 you will pay a quarterly fee of approximately $12.50 each month. In addition, participants in the Plan pay an annual fixed administrative fee of $120. This fee is deducted from your account at a rate of approximately $10 on a monthly basis.

The Northern California Carpenters 401(k) Plan may pay outside service providers for administrative services rendered during the year, such as recordkeeping and investment advisory services. Such amounts may be paid from a segregated account under the 401(k) Plan and/or may be charged against participants' accounts on a pro rata basis or as a specific dollar amount. Any amounts assessed against your account will be disclosed on a quarterly basis.

PARTICIPANT EXPENSES

The following expenses apply to all participants in the Northern California Carpenters 401(k) Plan if used by the participant. If any of these expenses apply to you, they will appear on your quarterly account statement. For more information regarding these expenses please refer to your Northern California Carpenters 401(k) Summary Plan Description (SPD). The SPD can be obtained by contacting John Hancock. Definitions of each of these expenses are included in the glossary described above and available at myplan.johnhancock.com.

Loan Fees	$100
Hardship Withdrawal Fee	$75
Insufficient Funds Fee	$25

ABILITY TO DIRECT INVESTMENTS

You have the right to transfer into or out of any investment option in your plan at any time, provided such transfer is permitted by the investment offeror. Investment options in your plan may have implemented restrictions such as redemption fees or short-term trading prohibitions. If redemption fees apply to any of the options in this plan, those fees and the holding period required to avoid the fees will be listed in the Fees and Expenses section above. Mutual funds are not appropriate for frequent trading and most mutual funds monitor and restrict such activity. If you conduct transactions in a particular fund too often or attempt to exchange among related funds soon after purchasing, the mutual fund may restrict or deny future purchases. The plan's named fiduciary, or its delegate, exercises voting, tender and any similar rights associated with the plan's designated investment alternatives unless the plan offers an employer stock investment alternative. In the case of employer stock, voting rights are generally exercised based upon participant instruction. Please review the funds' prospectuses for more information. To change any of your investments, you can go to myplan.johnhancock.com at any time, or you can call us at 833-388-6466 from 08:00 a.m. to 10:00 p.m. Eastern time on New York Stock Exchange business days. For your protection, all calls to our Representatives are recorded.

RESTRICTED INVESTMENTS

Mutual funds are not appropriate for frequent trading and most mutual funds monitor and restrict such activity. If you conduct transactions in a particular fund too often or attempt to exchange among related funds soon after purchasing, the mutual fund may restrict or deny future purchases. Please review the funds' prospectuses for more information.

ABOUT RISK

All investing involves risk. It is possible that your investment objectives may not be met. All mutual funds are subject to market risk and may fluctuate in value.

Neither John Hancock Retirement Plan Services, LLC, its affiliates nor its representatives provide tax, legal or accounting advice. Please contact your own advisors.

Please contact John Hancock at 833-388-6466 for a prospectus, and, if available, a summary prospectus. Investors are asked to consider the investment objectives, risks, and charges and expenses of the investment carefully before investing. The prospectus or summary prospectus, contains this and other information about the investment company. Please read this information carefully before investing.

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. Las horas de oficina son de 8:00 a.m. a 5:00 p.m., lunes a viernes. Usted también puede llamar a la oficina del Plan, teléfono 888-547-2054, para ayuda.

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

July 2022

To: **All Plan Participants and Beneficiaries**

From: **BOARD OF TRUSTEES**
Carpenters Annuity Trust Fund for Northern California

Re: **Individual Account Self-Direction**

This Notice is to remind you that you have the **option** to direct the investments of your Individual Annuity Account through the Plan's Self-Direct program. You are not required to participate in the Self-Direct program, but it is a feature available to those who would like to pick their own investment options from a select list, and have qualified to do so.

- If you would like to review your Account, log in at carpenterfunds.com.
- If you do not already have a participant login, click the link to register after going to the login page.

<table>
<tr><th>To Continue with a Professionally Managed Account</th><th>To Self-Direct Your Investments</th></tr>
<tr><td rowspan="2">No action is required. Your account will continue to be Professionally Managed.</td><td>To Get Started:
Visit www.carpenterfunds.com, under the Retirement-Annuity tab and click the link labeled “Self-Direct Online Seminar” to watch an online educational program about your investment options.</td></tr>
<tr><td>Choosing Investment Options:
Once you have completed the online educational program, you may request all or a part of your Individual Annuity Account be transferred to John Hancock where you can direct your Account within a variety of mutual and target-date retirement funds. Pensionmark, the Plan's financial advisor, can answer questions about investment options and can be reached at (888) 201-5488 or www.Pensionmark.com.</td></tr>
<tr><th colspan="2">View Plan and Account Information Online</th></tr>
<tr><th>www.carpenterfunds.com</th><th>www.myplan.johnhancock.com</th></tr>
</table>

The portion of the Plan allocated to the Self-Directed Subaccount is intended to comply with Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA). This means the fiduciaries of the Plan may be relieved of liability for any losses, which are the direct and necessary result of investment instructions given by you with respect to that portion of your Individual Account allocated to the Self-Directed Subaccount.

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.

IMPORTANT INFORMATION REGARDING THE NORTHERN CALIFORNIA CARPENTERS 401(k) PLAN

To:	All Participants
From:	Plan Administrator of the Northern California Carpenters 401(k) Plan (the "Plan")
Plan Sponsor:	Board of Trustees, Northern California Carpenters 401(k) Plan
Date:	July 2022

This is an annual notice which only applies to the 2022 Plan Year.

Please read this notice carefully, as it contains important information about certain features of the Plan. To obtain more general information about the Plan, you should obtain a copy of the Plan's Summary Plan Description ("SPD"). See "FOR ADDITIONAL INFORMATION" below for information on how you can obtain a copy of the Plan's current SPD.

NOTE: *Many of your Plan elections are made by contacting John Hancock Retirement Plan Services ("John Hancock"). If you wish to contact John Hancock, you may do so:*

- *24 hours a day via either the internet at myplan.johnhancock.com or an automated telephone system at 833.388.6466.*
- *8AM to 10PM Eastern Time by calling 833.388.6466 to speak with a Participant Service Representative.*

QUALIFIED DEFAULT INVESTMENT ALTERNATIVE

You have the right to direct the investment of your account among any of the investment options available under the Plan. Information concerning the available options has been provided to you. If you become a participant in the Plan and do not have an investment election on file, any contribution made on your behalf will be invested in the Plan's qualified default investment, the Pensionmark Asset Allocation Portfolio, based on your year of birth, according to the chart below:

Date of Birth	Default Investment
On or before 1953	Pensionmark Asset Allocation Income
1954 - 1958	Pensionmark Asset Allocation 2020
1959 - 1963	Pensionmark Asset Allocation 2025
1964 - 1968	Pensionmark Asset Allocation 2030
1969 - 1973	Pensionmark Asset Allocation 2035
1974 - 1978	Pensionmark Asset Allocation 2040
1979 - 1983	Pensionmark Asset Allocation 2045
1984 - 1988	Pensionmark Asset Allocation 2050
1989 - 1993	Pensionmark Asset Allocation 2055
1994 or later	Pensionmark Asset Allocation 2060

If John Hancock does not have your date of birth on file, contributions will be invested instead in the Pensionmark Asset Allocation Income Portfolio until a valid date of birth is obtained by John Hancock.

IMPORTANT INFORMATION REGARDING THE NORTHERN CALIFORNIA CARPENTERS 401(k) Plan

This investment is intended to satisfy the requirements for a "qualified default investment alternative" ("QDIA") under the Employee Retirement Income Security Act of 1974 ("ERISA"). A copy of the Fund Fact Sheet for the Plan's default investment is attached to this Notice.

If you do not make an investment election and your account is invested in the QDIA, you may transfer all or any part of it from the QDIA into any other investment options by contacting John Hancock. Information regarding all of the Plan's investment options and procedures for changing investment elections is available by contacting John Hancock.

Amounts defaulted into the Plan's Stable Value Option prior to December 24, 2007 will also be considered a QDIA pursuant to a special QDIA transition rule.

About Risk

Investing in Target Date Funds: The "target date" in a target date fund is the approximate date an investor plans to start withdrawing money. Because target date funds are managed to specific retirement dates, investors may be taking on greater risk if the actual year of retirement differs dramatically from the original estimated date. Target date funds generally shift to a more conservative investment mix over time. While this may help to manage risk, it does not guarantee earnings growth nor is the fund's principal value guaranteed at any time including at the target date. You do not have the ability to actively manage the investments within target date funds. The portfolio managers control security selection and asset allocation. Target Date funds allocate their investments among multiple asset classes which can include U.S. and foreign equity and fixed income securities.

FOR ADDITIONAL INFORMATION

You should consult the Plan document and SPD for a complete explanation of the Plan's features and information. You may view and/or obtain a copy of the SPD by contacting John Hancock. You can also obtain additional information about the Plan by contacting John Hancock or by contacting the Plan Sponsor.

This Notice is not intended to, nor should you construe it as, modifying any aspect of the current Plan document or SPD.

S-P27617-GE 10/15-255636
RS101415255636

IMPORTANT INFORMATION REGARDING THE CARPENTERS ANNUITY TRUST FUND FOR NORTHERN CALIFORNIA

To:	All Participants
From:	Plan Administrator of the Carpenters Annuity Trust Fund for Northern California (the "Plan")
Plan Sponsor:	Board of Trustees, Carpenters Annuity Trust Fund for Northern California
Date:	July 2022

This is an annual notice which only applies to the 2022 Plan Year.

Please read this notice carefully, as it contains important information about certain features of the Plan. To obtain more general information about the Plan, you should obtain a copy of the Plan's Summary Plan Description ("SPD"). See "FOR ADDITIONAL INFORMATION" below for information on how you can obtain a copy of the Plan's current SPD.

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- *24 hours a day via either the internet at myplan.johnhancock.com or an automated telephone system at 833.388.6466.*
- *8AM to 10PM Eastern Time by calling 833.388.6466 to speak with a Participant Service Representative.*

QUALIFIED DEFAULT INVESTMENT ALTERNATIVE

You have the right to direct the investment of your account among any of the investment options available under the Plan. Information concerning the available options has been provided to you. If you become a participant in the Plan and do not have an investment election on file, any contribution made on your behalf will be invested in the Plan's qualified default investment, the Pensionmark Asset Allocation Portfolio, based on your year of birth, according to the chart below:

Date of Birth	Default Investment
On or before 1953	Pensionmark Asset Allocation Income
1954 - 1958	Pensionmark Asset Allocation 2020
1959 - 1963	Pensionmark Asset Allocation 2025
1964 - 1968	Pensionmark Asset Allocation 2030
1969 - 1973	Pensionmark Asset Allocation 2035
1974 - 1978	Pensionmark Asset Allocation 2040
1979 - 1983	Pensionmark Asset Allocation 2045
1984 - 1988	Pensionmark Asset Allocation 2050
1989 - 1993	Pensionmark Asset Allocation 2055
1994 or later	Pensionmark Asset Allocation 2060

If John Hancock does not have your date of birth on file, contributions will be invested instead in the Pensionmark Asset Allocation Income Portfolio until a valid date of birth is obtained by John Hancock.

IMPORTANT INFORMATION
REGARDING THE
CARPENTERS ANNUITY TRUST FUND FOR NORTHERN CALIFORNIA

This investment is intended to satisfy the requirements for a "qualified default investment alternative" ("QDIA") under the Employee Retirement Income Security Act of 1974 ("ERISA"). A copy of the Fund Fact Sheet for the Plan's default investment is attached to this Notice.

If you do not make an investment election and your account is invested in the QDIA, you may transfer all or any part of it from the QDIA into any other investment options by contacting John Hancock. Information regarding all of the Plan's investment options and procedures for changing investment elections is available by contacting John Hancock.

Amounts defaulted into the Plan's Stable Value Option prior to December 24, 2007 will also be considered a QDIA pursuant to a special QDIA transition rule.

About Risk

Investing in Target Date Funds: The "target date" in a target date fund is the approximate date an investor plans to start withdrawing money. Because target date funds are managed to specific retirement dates, investors may be taking on greater risk if the actual year of retirement differs dramatically from the original estimated date. Target date funds generally shift to a more conservative investment mix over time. While this may help to manage risk, it does not guarantee earnings growth nor is the fund's principal value guaranteed at any time including at the target date. You do not have the ability to actively manage the investments within target date funds. The portfolio managers control security selection and asset allocation. Target Date funds allocate their investments among multiple asset classes which can include U.S. and foreign equity and fixed income securities.

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S-P27617-GE 10/15-255636
RS101415255636

John Hancock

Pensionmark Asset Allocation 2020

AS OF 2022-06-30

INVESTMENT STRATEGY: Target date portfolios are also offered as investment options in the Plan. Each portfolio is structured to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by mutual funds and the Stable Value Option. The Portfolios themselves are not mutual funds. The underlying investment options that make up this portfolio were selected by a financial intermediary not associated with John Hancock Retirement Plan Services, LLC. This portfolio will be re-balanced quarterly by John Hancock Retirement Plan Services, LLC and reviewed annually by the intermediary to ensure that the allocation percentages continue to fit the Portfolio's objective.

Fund Category:
Balanced/Asset Allocation

PORTFOLIO DETAILS

Inception Date	2012-11-09
Gross Expense Ratio[f1] (%)	0.26
Net Expense Ratio[f1] (%)	0.26
Fund Total Net Assets ($M)	10.02

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Western Asset Core Plus Bd IS	35.98
Vanguard 500 Index Fd Admiral	17.26
NYL Guaranteed Int. Acct.	13.00
Vanguard Intl Growth Fund Adm	11.71
Vanguard Sm Cap Index Fd Adm	7.97
Vanguard Inf-Prot Secs (Inst)	6.71
American New World Fund R6	2.75
Janus Henderson Dev World Bd N	2.68
Cohen & Steers Real Est Sec Z	1.94

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk and Target Date. See disclosure for details.

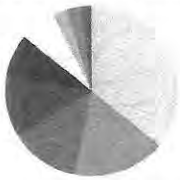
Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation 2020	-17.36	-15.90	3.76	4.98	--	5.49
Morningstar Lifetime Moderate[i87]	-16.70	-13.95	2.75	4.36	5.81	--

Performance data quoted represents past performance. Past performance is no guarantee of future results. Due to market volatility, current performance may be less or higher than the figures shown. Investment return and principal value will fluctuate so that upon redemption, shares may be worth more or less than their original cost. Performance data does not reflect deduction of redemption fee, which, if such fee exists, would lower performance. For current to the most recent month-end performance information, please log onto myplan.johnhancock.com or call a John Hancock representative at (800) 294-3575.

Portfolio Snapshot[b2] (%)



35.98	Western Asset Core Plus Bd IS	6.71	Vanguard Inf-Prot Secs (Inst)
17.26	Vanguard 500 Index Fd Admiral	2.75	American New World Fund R6
13.00	NYL Guaranteed Int. Acct.	2.68	Janus Henderson Dev World Bd N
11.71	Vanguard Intl Growth Fund Adm	1.94	Cohen & Steers Real Est Sec Z
7.97	Vanguard Sm Cap Index Fd Adm		

f1. The Gross Expense Ratio does not include fee waivers or expense reimbursements which result in lower actual cost to the investor. The Net Expense Ratio represents the effect of a fee waiver and/or expense reimbursement and is subject to change.

Marketing support services are provided by John Hancock Distributors LLC.

The target date is the expected year in which participants in a Target Date Portfolio plan to retire and no longer make contributions. The investment strategy of these Portfolios are designed to become more conservative over time as the target date approaches (or if applicable passes) the target retirement date. The principal value of your investment as well as your potential rate of return, are not guaranteed at any time, including at or after the target retirement date. An investor should examine the asset allocation of the fund to ensure it is consistent with their own risk tolerance.

John Hancock

Pensionmark Asset Allocation 2025

AS OF 2022-06-30

INVESTMENT STRATEGY: Target date portfolios are also offered as investment options in the Plan. Each portfolio is structured to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by mutual funds and the Stable Value Option. The Portfolios themselves are not mutual funds. The underlying investment options that make up this portfolio were selected by a financial intermediary not associated with John Hancock Retirement Plan Services, LLC. This portfolio will be re-balanced quarterly by John Hancock Retirement Plan Services, LLC and reviewed annually by the intermediary to ensure that the allocation percentages continue to fit the Portfolio's objective.

Fund Category: **Balanced/Asset Allocation**

PORTFOLIO DETAILS

Inception Date	2012-11-09
Gross Expense Ratio[f1] (%)	0.23
Net Expense Ratio[f1] (%)	0.23
Fund Total Net Assets ($M)	20.12

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Western Asset Core Plus Bd IS	26.09
Vanguard 500 Index Fd Admiral	23.47
Vanguard Intl Growth Fund Adm	15.82
NYL Guaranteed Int. Acct.	12.48
Vanguard Sm Cap Index Fd Adm	9.11
Vanguard Inf-Prot Secs (Inst)	5.10
American New World Fund R6	3.28
Cohen & Steers Real Est Sec Z	2.48
Janus Henderson Dev World Bd N	2.17

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk, Private Fund and Target Date. See disclosure for details.

Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation 2025	-18.49	-16.72	5.06	5.92	--	6.35
Morningstar Lifetime Moderate[i88]	-17.74	-14.87	2.93	4.66	6.49	--

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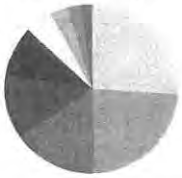
Portfolio Snapshot[b2] (%)



26.09	Western Asset Core Plus Bd IS	5.10	Vanguard Inf-Prot Secs (Inst)		
23.47	Vanguard 500 Index Fd Admiral	3.28	American New World Fund R6		
15.82	Vanguard Intl Growth Fund Adm	2.48	Cohen & Steers Real Est Sec Z		
12.48	NYL Guaranteed Int. Acct.	2.17	Janus Henderson Dev World Bd N		
9.11	Vanguard Sm Cap Index Fd Adm				

f1. The Gross Expense Ratio does not include fee waivers or expense reimbursements which result in lower actual cost to the investor. The Net Expense Ratio represents the effect of a fee waiver and/or expense reimbursement and is subject to change.

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The target date is the expected year in which participants in a Target Date Portfolio plan to retire and no longer make contributions. The investment strategy of these Portfolios are designed to become more conservative over time as the target date approaches (or if applicable passes) the target retirement date. The principal value of your investment as well as your potential rate of return, are not guaranteed at any time, including at or after the target retirement date. An investor should examine the asset allocation of the fund to ensure it is consistent with their own risk tolerance.

John Hancock

Pensionmark Asset Allocation 2030

AS OF 2022-06-30

INVESTMENT STRATEGY: Target date portfolios are also offered as investment options in the Plan. Each portfolio is structured to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by mutual funds and the Stable Value Option. The Portfolios themselves are not mutual funds. The underlying investment options that make up this portfolio were selected by a financial intermediary not associated with John Hancock Retirement Plan Services, LLC. This portfolio will be re-balanced quarterly by John Hancock Retirement Plan Services, LLC and reviewed annually by the intermediary to ensure that the allocation percentages continue to fit the Portfolio's objective.

Fund Category:
Balanced/Asset Allocation

PORTFOLIO DETAILS

Inception Date	2012-11-09
Gross Expense Ratio[f1] (%)	0.22
Net Expense Ratio[f1] (%)	0.22
Fund Total Net Assets ($M)	20.79

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Vanguard 500 Index Fd Admiral	28.89
Vanguard Intl Growth Fund Adm	19.74
Western Asset Core Plus Bd IS	19.10
NYL Guaranteed Int. Acct.	10.06
Vanguard Sm Cap Index Fd Adm	9.76
American New World Fund R6	3.83
Cohen & Steers Real Est Sec Z	3.54
Vanguard Inf-Prot Secs (Inst)	3.43
Janus Henderson Dev World Bd N	1.65

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk, Private Fund and Target Date. See disclosure for details.

Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation 2030	-20.07	-18.01	5.97	6.62	--	7.07
Morningstar Lifetime Moderate[i89]	-18.57	-15.55	3.30	5.07	7.23	--

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Portfolio Snapshot[b2] (%)

28.89	Vanguard 500 Index Fd Admiral	3.83	American New World Fund R6		
19.74	Vanguard Intl Growth Fund Adm	3.54	Cohen & Steers Real Est Sec Z		
19.10	Western Asset Core Plus Bd IS	3.43	Vanguard Inf-Prot Secs (Inst)		
10.06	NYL Guaranteed Int. Acct.	1.65	Janus Henderson Dev World Bd N		
9.76	Vanguard Sm Cap Index Fd Adm				

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Marketing support services are provided by John Hancock Distributors LLC.

The target date is the expected year in which participants in a Target Date Portfolio plan to retire and no longer make contributions. The investment strategy of these Portfolios are designed to become more conservative over time as the target date approaches (or if applicable passes) the target retirement date. The principal value of your investment as well as your potential rate of return, are not guaranteed at any time, including at or after the target retirement date. An investor should examine the asset allocation of the fund to ensure it is consistent with their own risk tolerance.

John Hancock

Pensionmark Asset Allocation 2035

AS OF 2022-06-30

INVESTMENT STRATEGY: Target date portfolios are also offered as investment options in the Plan. Each portfolio is structured to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by mutual funds and the Stable Value Option. The Portfolios themselves are not mutual funds. The underlying investment options that make up this portfolio were selected by a financial intermediary not associated with John Hancock Retirement Plan Services, LLC. This portfolio will be re-balanced quarterly by John Hancock Retirement Plan Services, LLC and reviewed annually by the intermediary to ensure that the allocation percentages continue to fit the Portfolio's objective.

Fund Category:
Balanced/Asset Allocation

PORTFOLIO DETAILS

Inception Date	2012-11-09
Gross Expense Ratio[f1] (%)	0.21
Net Expense Ratio[f1] (%)	0.21
Fund Total Net Assets ($M)	14.37

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Vanguard 500 Index Fd Admiral	33.33
Vanguard Intl Growth Fund Adm	22.55
Western Asset Core Plus Bd IS	11.84
Vanguard Sm Cap Index Fd Adm	10.88
NYL Guaranteed Int. Acct.	8.97
Cohen & Steers Real Est Sec Z	4.62
American New World Fund R6	4.36
Vanguard Inf-Prot Secs (Inst)	2.33
Janus Henderson Dev World Bd N	1.12

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk and Target Date. See disclosure for details.

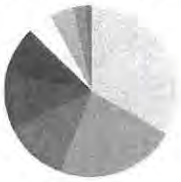
Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation 2035	-21.10	-18.78	6.82	7.31	--	7.83
Morningstar Lifetime Moderate[i90]	-19.07	-15.92	3.81	5.52	7.83	--

Performance data quoted represents past performance. Past performance is no guarantee of future results. Due to market volatility, current performance may be less or higher than the figures shown. Investment return and principal value will fluctuate so that upon redemption, shares may be worth more or less than their original cost. Performance data does not reflect deduction of redemption fee, which, if such fee exists, would lower performance. For current to the most recent month-end performance information, please log onto myplan.johnhancock.com or call a John Hancock representative at (800) 294-3575.

Portfolio Snapshot[b2] (%)



33.33	Vanguard 500 Index Fd Admiral	4.62	Cohen & Steers Real Est Sec Z
22.55	Vanguard Intl Growth Fund Adm	4.36	American New World Fund R6
11.84	Western Asset Core Plus Bd IS	2.33	Vanguard Inf-Prot Secs (Inst)
10.88	Vanguard Sm Cap Index Fd Adm	1.12	Janus Henderson Dev World Bd N
8.97	NYL Guaranteed Int. Acct.		

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John Hancock

Pensionmark Asset Allocation 2040

AS OF 2022-06-30

INVESTMENT STRATEGY: Target date portfolios are also offered as investment options in the Plan. Each portfolio is structured to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by mutual funds and the Stable Value Option. The Portfolios themselves are not mutual funds. The underlying investment options that make up this portfolio were selected by a financial intermediary not associated with John Hancock Retirement Plan Services, LLC. This portfolio will be re-balanced quarterly by John Hancock Retirement Plan Services, LLC and reviewed annually by the intermediary to ensure that the allocation percentages continue to fit the Portfolio's objective.

Fund Category:
Balanced/Asset Allocation

PORTFOLIO DETAILS

Inception Date	2012-11-09
Gross Expense Ratio[f1] (%)	0.20
Net Expense Ratio[f1] (%)	0.20
Fund Total Net Assets ($M)	12.04

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Vanguard 500 Index Fd Admiral	38.56
Vanguard Intl Growth Fund Adm	27.04
Vanguard Sm Cap Index Fd Adm	11.59
NYL Guaranteed Int. Acct.	6.49
Western Asset Core Plus Bd IS	5.47
Cohen & Steers Real Est Sec Z	5.22
American New World Fund R6	4.45
Vanguard Inf-Prot Secs (Inst)	1.18

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk, Private Fund and Target Date. See disclosure for details.

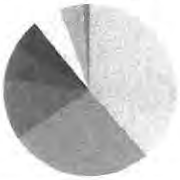
Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation 2040	-22.49	-20.01	7.69	7.96	--	8.56
Morningstar Lifetime Moderate[i91]	-19.40	-16.14	4.27	5.87	8.18	--

Performance data quoted represents past performance. Past performance is no guarantee of future results. Due to market volatility, current performance may be less or higher than the figures shown. Investment return and principal value will fluctuate so that upon redemption, shares may be worth more or less than their original cost. Performance data does not reflect deduction of redemption fee, which, if such fee exists, would lower performance. For current to the most recent month-end performance information, please log onto myplan.johnhancock.com or call a John Hancock representative at (800) 294-3575.

Portfolio Snapshot[b2] (%)



38.56	Vanguard 500 Index Fd Admiral	5.47	Western Asset Core Plus Bd IS
27.04	Vanguard Intl Growth Fund Adm	5.22	Cohen & Steers Real Est Sec Z
11.59	Vanguard Sm Cap Index Fd Adm	4.45	American New World Fund R6
6.49	NYL Guaranteed Int. Acct.	1.18	Vanguard Inf-Prot Secs (Inst)

f1. The Gross Expense Ratio does not include fee waivers or expense reimbursements which result in lower actual cost to the investor. The Net Expense Ratio represents the effect of a fee waiver and/or expense reimbursement and is subject to change.

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John Hancock

Pensionmark Asset Allocation 2045

AS OF 2022-06-30

INVESTMENT STRATEGY: Target date portfolios are also offered as investment options in the Plan. Each portfolio is structured to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by mutual funds and the Stable Value Option. The Portfolios themselves are not mutual funds. The underlying investment options that make up this portfolio were selected by a financial intermediary not associated with John Hancock Retirement Plan Services, LLC. This portfolio will be re-balanced quarterly by John Hancock Retirement Plan Services, LLC and reviewed annually by the intermediary to ensure that the allocation percentages continue to fit the Portfolio's objective.

Fund Category:
Balanced/Asset Allocation

PORTFOLIO DETAILS

Inception Date	2012-11-09
Gross Expense Ratio[f1] (%)	0.20
Net Expense Ratio[f1] (%)	0.20
Fund Total Net Assets ($M)	9.34

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Vanguard 500 Index Fd Admiral	40.58
Vanguard Intl Growth Fund Adm	30.62
Vanguard Sm Cap Index Fd Adm	11.73
Cohen & Steers Real Est Sec Z	5.81
American New World Fund R6	5.01
NYL Guaranteed Int. Acct.	4.58
Western Asset Core Plus Bd IS	1.67

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk, Private Fund and Target Date. See disclosure for details.

Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation 2045	-23.50	-21.09	8.09	8.29	--	9.09
Morningstar Lifetime Moderate[b2]	-19.58	-16.28	4.53	6.03	8.28	--

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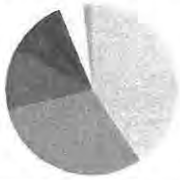
Portfolio Snapshot[b2] (%)



40.58	Vanguard 500 Index Fd Admiral	5.01	American New World Fund R6
30.62	Vanguard Intl Growth Fund Adm	4.58	NYL Guaranteed Int. Acct.
11.73	Vanguard Sm Cap Index Fd Adm	1.67	Western Asset Core Plus Bd IS
5.81	Cohen & Steers Real Est Sec Z		

f1. The Gross Expense Ratio does not include fee waivers or expense reimbursements which result in lower actual cost to the investor. The Net Expense Ratio represents the effect of a fee waiver and/or expense reimbursement and is subject to change.

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John Hancock

Pensionmark Asset Allocation 2050

AS OF 2022-06-30

INVESTMENT STRATEGY: Target date portfolios are also offered as investment options in the Plan. Each portfolio is structured to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by mutual funds and the Stable Value Option. The Portfolios themselves are not mutual funds. The underlying investment options that make up this portfolio were selected by a financial intermediary not associated with John Hancock Retirement Plan Services, LLC. This portfolio will be re-balanced quarterly by John Hancock Retirement Plan Services, LLC and reviewed annually by the intermediary to ensure that the allocation percentages continue to fit the Portfolio's objective.

Fund Category: **Balanced/Asset Allocation**

PORTFOLIO DETAILS

Inception Date	2012-11-09
Gross Expense Ratio[f1] (%)	0.20
Net Expense Ratio[f1] (%)	0.20
Fund Total Net Assets ($M)	9.47

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Vanguard 500 Index Fd Admiral	41.99
Vanguard Intl Growth Fund Adm	32.30
Vanguard Sm Cap Index Fd Adm	12.35
Cohen & Steers Real Est Sec Z	5.86
American New World Fund R6	5.05
NYL Guaranteed Int. Acct.	1.32
Western Asset Core Plus Bd IS	1.13

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk, Private Fund and Target Date. See disclosure for details.

Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation 2050	-24.23	-21.85	8.21	8.45	--	9.52
Morningstar Lifetime Moderate[i93]	-19.63	-16.40	4.59	6.04	8.25	--

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Portfolio Snapshot[b2] (%)

41.99	Vanguard 500 Index Fd Admiral	5.05	American New World Fund R6
32.30	Vanguard Intl Growth Fund Adm	1.32	NYL Guaranteed Int. Acct.
12.35	Vanguard Sm Cap Index Fd Adm	1.13	Western Asset Core Plus Bd IS
5.86	Cohen & Steers Real Est Sec Z		

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John Hancock

Pensionmark Asset Allocation 2055

AS OF 2022-06-30

INVESTMENT STRATEGY: Target date portfolios are also offered as investment options in the Plan. Each portfolio is structured to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by mutual funds and the Stable Value Option. The Portfolios themselves are not mutual funds. The underlying investment options that make up this portfolio were selected by a financial intermediary not associated with John Hancock Retirement Plan Services, LLC. This portfolio will be re-balanced quarterly by John Hancock Retirement Plan Services, LLC and reviewed annually by the intermediary to ensure that the allocation percentages continue to fit the Portfolio's objective.

Fund Category: **Balanced/Asset Allocation**

PORTFOLIO DETAILS

Inception Date	2015-06-10
Gross Expense Ratio[f1] (%)	0.20
Net Expense Ratio[f1] (%)	0.20
Fund Total Net Assets ($M)	3.99

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Vanguard 500 Index Fd Admiral	41.90
Vanguard Intl Growth Fund Adm	32.45
Vanguard Sm Cap Index Fd Adm	12.33
Cohen & Steers Real Est Sec Z	5.85
American New World Fund R6	5.05
NYL Guaranteed Int. Acct.	1.31
Western Asset Core Plus Bd IS	1.11

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk, Private Fund and Target Date. See disclosure for details.

Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation 2055	-24.23	-21.85	8.21	8.58	--	8.34
Morningstar Lifetime Moderate[i93]	-19.63	-16.40	4.59	6.04	8.25	--

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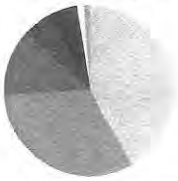
Portfolio Snapshot[b2] (%)



41.90	Vanguard 500 Index Fd Admiral	5.05	American New World Fund R6
32.45	Vanguard Intl Growth Fund Adm	1.31	NYL Guaranteed Int. Acct.
12.33	Vanguard Sm Cap Index Fd Adm	1.11	Western Asset Core Plus Bd IS
5.85	Cohen & Steers Real Est Sec Z		

f1. The Gross Expense Ratio does not include fee waivers or expense reimbursements which result in lower actual cost to the investor. The Net Expense Ratio represents the effect of a fee waiver and/or expense reimbursement and is subject to change.

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John Hancock

Pensionmark Asset Allocation 2060

AS OF 2022-06-30

INVESTMENT STRATEGY: Target date portfolios are also offered as investment options in the Plan. Each portfolio is structured to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by mutual funds and the Stable Value Option. The Portfolios themselves are not mutual funds. The underlying investment options that make up this portfolio were selected by a financial intermediary not associated with John Hancock Retirement Plan Services, LLC. This portfolio will be re-balanced quarterly by John Hancock Retirement Plan Services, LLC and reviewed annually by the intermediary to ensure that the allocation percentages continue to fit the Portfolio's objective.

Fund Category: **Balanced/Asset Allocation**

PORTFOLIO DETAILS

Inception Date	2015-08-10
Gross Expense Ratio[f1] (%)	0.20
Net Expense Ratio[f1] (%)	0.20
Fund Total Net Assets ($M)	2.03

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Vanguard 500 Index Fd Admiral	41.84
Vanguard Intl Growth Fund Adm	32.54
Vanguard Sm Cap Index Fd Adm	12.31
Cohen & Steers Real Est Sec Z	5.84
American New World Fund R6	5.05
NYL Guaranteed Int. Acct.	1.30
Western Asset Core Plus Bd IS	1.12

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk, Private Fund and Target Date. See disclosure for details.

Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation 2060	-24.23	-21.86	8.21	8.67	--	8.68
Morningstar Lifetime Moderate[i93]	-19.63	-16.40	4.59	6.04	8.25	--

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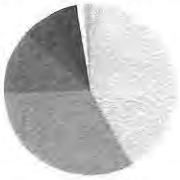
Portfolio Snapshot[b2] (%)



41.84	Vanguard 500 Index Fd Admiral	5.05	American New World Fund R6		
32.54	Vanguard Intl Growth Fund Adm	1.30	NYL Guaranteed Int. Acct.		
12.31	Vanguard Sm Cap Index Fd Adm	1.12	Western Asset Core Plus Bd IS		
5.84	Cohen & Steers Real Est Sec Z				

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John Hancock

Pensionmark Asset Allocation Income

AS OF 2022-06-30

INVESTMENT STRATEGY: Portfolios Asset Allocations are also offered as investment options in the Plan. Each Portfolio seeks to achieve the highest potential rate of return for its objective and level of risk by allocating assets in varying percentages to different asset classes, represented by the portfolio's investment vehicles. The percentage of assets allocated to each asset class will be rebalanced by John Hancock Retirement Plan Services, LLC according to the rebalancing rules provided by the client or financial intermediary. The Portfolios themselves are not mutual funds.

Fund Category: **Balanced/Asset Allocation**

PORTFOLIO DETAILS

Inception Date	2012-11-09
Gross Expense Ratio[f1] (%)	0.26
Net Expense Ratio[f1] (%)	0.26
Fund Total Net Assets ($M)	4.95

TOP TEN HOLDINGS AS OF 2022-06-30

	% of Assets
Western Asset Core Plus Bd IS	41.90
Vanguard 500 Index Fd Admiral	14.21
NYL Guaranteed Int. Acct.	13.25
Vanguard Inf-Prot Secs (Inst)	8.75
Vanguard Intl Growth Fund Adm	8.09
Vanguard Sm Cap Index Fd Adm	7.42
Janus Henderson Dev World Bd N	3.15
American New World Fund R6	2.27
Cohen & Steers Real Est Sec Z	0.96

PRINCIPAL RISKS

Principal Risks include: Portfolio Risk and Target Date. See disclosure for details.

Average Annual Total Returns %

As of 2022-06-30

	YTD	1 Year	3 Year	5 Year	10 Year	Since Inception
Pensionmark Asset Allocation Income	-16.20	-14.82	2.86	4.30	--	4.47
Morningstar Lifetime Moderate[IB4]	-12.35	-10.02	2.79	3.85	4.25	--

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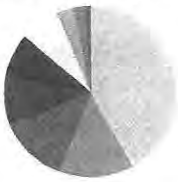
Portfolio Snapshot[b2] (%)



41.90	Western Asset Core Plus Bd IS	7.42	Vanguard Sm Cap Index Fd Adm		
14.21	Vanguard 500 Index Fd Admiral	3.15	Janus Henderson Dev World Bd N		
13.25	NYL Guaranteed Int. Acct.	2.27	American New World Fund R6		
8.75	Vanguard Inf-Prot Secs (Inst)	0.96	Cohen & Steers Real Est Sec Z		
8.09	Vanguard Intl Growth Fund Adm				

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John Hancock

Risks and Disclosures

Important Notes

Other:

b2. The portfolio composition, industry sectors, top ten holdings, and credit analysis are presented to illustrate examples of securities that the fund has bought and diversity of areas in which the fund may invest and may not be representative of the fund's current or future investments. The top ten holdings do not include money market instruments and/or futures contracts. The figures presented are as of date shown, do not include the fund's entire investment portfolio, and may change at any time.

Index Description:

i84. The Morningstar Lifetime Moderate Income Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a t

i87. The Morningstar Lifetime Moderate 2020 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a tar

i88. The Morningstar Lifetime Moderate 2025 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a tar

i89. The Morningstar Lifetime Moderate 2030 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a tar

i90. The Morningstar Lifetime Moderate 2035 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a tar

i91. The Morningstar Lifetime Moderate 2040 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a tar

i92. The Morningstar Lifetime Moderate 2045 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a tar

i93. The Morningstar Lifetime Moderate 2050 Index measures the performance of a portfolio of global equities, bonds and traditional inflation hedges such as commodities and TIPS. This portfolio is held in proportions appropriate for a US investor who has a tar

Principal Risks

Portfolio Risk: This not a mutual fund, prospectuses are not required, and prices are not available in local publications. The portfolio allocates its investments among multiple asset classes, which can include U.S. and foreign equity and fixed income securities. Foreign investing involves risks not associated with U.S. investments, including currency fluctuations and political and economic changes. These risks are likely to be greater for emerging markets than in developed markets. Portfolios that invest in bonds are subject to interest-rate risk and can lose principal value when interest rates rise. The portfolio may also allocate its investments in growth and value stocks, real estate investment trusts, and corporate and U.S. government bonds. Asset allocation does not ensure a profit or protection against a loss. Please note that asset allocation may not be appropriate for all participants particularly those interested in directing investment options on their own. Consider the investment objectives, risks, charges, and expenses of the fund carefully before investing. An investor should examine the asset allocation of the portfolio to ensure it is consistent with their own risk tolerance.

Private Fund: The fund is not a mutual fund and is privately offered. Prospectuses are not required and prices are not available in local publications.

Target Date: Target-date funds, also known as lifecycle funds, shift their asset allocation to become increasingly conservative as the target retirement year approaches. Still, investment in target-date funds may lose value near, at, or after the target retirement date, and there is no guarantee they will provide adequate income at retirement.

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

September 23, 2022

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: Health and Welfare Plan Benefit Changes

- **Increased Life and AD&D Insurance Benefit**
- **Exclusion and Limitation for Nutritional Counseling or Food Supplements or Substitutes**
- **90-Day Supply of Medication at Retail Pharmacies**

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.

HEALTH AND WELFARE PLAN BENEFIT IMPROVEMENTS

Active Plan Participants: Life and AD&D Insurance Benefit

Effective September 1, 2022, the Trustees approved an increase to your Life Insurance and Accidental Death and Dismemberment (AD&D) benefits.

- $20,000 in group life insurance benefits will be paid to your beneficiary in the event of your death from any cause while eligible under the Plan.
- Up to $20,000 in AD&D benefits will be paid for death or dismemberment due to an accident that happens on or off the job, and if:
  - You are eligible under the Health Plan on the date of the accident,
  - The death or dismemberment occurs within 180 days after the accident, and
  - The cause of death or dismemberment is not excluded.

Life Insurance benefits provided for your eligible Dependents including Spouse/Domestic Partner and Dependent child(ren) up to age 21 have also increased, as follows:

- Spouse or Domestic Partner - $5,000
- Children less than 21 years of age - $1,000

These benefits are available to Participants, Spouses/Domestic Partners and eligible Dependent child(ren) up to age 21 who are enrolled in Plans A, B and Flat Rate (both Indemnity Medical Plan and the Kaiser HMO Plan). These benefits are not available to participants or dependents who are covered under Plan R.

The full Schedule of Benefits is available at the Trust Fund Office upon request.

Indemnity Plan Participants Only

Nutritional Counseling or Food Supplements or Substitutes

Effective December 1, 2021 there was a change to your Health Plan for coverage of food supplements or substitutes. Nutritional counseling or food supplements or substitutes are typically excluded under the Plan. However, this exclusion no longer applies to nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health condition, such as an eating disorder. In addition, this exclusion does not apply to Total Parenteral Nutrition (TPN) that is approved by Anthem as Medically Necessary and is curative in nature.

90-Day Supply of Medication Now Available at Many Retail Pharmacies

Beginning September 1, 2022, access to a 3-month supply of your prescription medication is now available at many retail pharmacies. You may now avoid paying higher costs by choosing to receive your 90-day supply via mail order or directly from a participating retail pharmacy.

Choose your way to save with a 3-month supply	
Express Scripts Pharmacy	**Participating Retail Pharmacies**
• Delivered to your door with free standard shipping	• At convenient locations near you
• Transfer prescriptions easily online by phone or Express Scripts mobile app	• Transfer your prescriptions easily in-store, by phone or online
• Auto-refills and refill reminders available	• Ask about auto refills and refill reminders
• Talk with a pharmacist by phone 24/7	• Log in online @ express-scripts.com/90day or contact us to find more participating pharmacies in your area.

****

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.

carpenterfunds.com

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

December 21, 2022

TO: **All Participants, Beneficiaries, Participating Local Unions, and Contributing Employers**

FROM: **Board of Trustees**

RE: **Carpenters Pension Trust Fund for Northern California**
Notice of Critical Status – EIN #94-6050970
Plan Year: September 1, 2022 – August 31, 2023

If you are currently retired and receiving a monthly benefit payment from the Pension Fund, your monthly check will continue uninterrupted.

The Pension Protection Act of 2006 ("PPA") imposed rules designed to accelerate the funding of defined benefit plans like the Carpenters Pension Trust Fund for Northern California. Previously, plans were required to address funding issues only when a plan would not satisfy minimum funding standards for the current year, and could spread investment losses over longer periods of time. Alternatively, the PPA mandates that plans accelerate funding, anticipate future funding issues based upon projections, and for those certified to be in critical status to develop a "Rehabilitation Plan."

Federal law requires that you receive this notice. Following the determination of critical status ("red zone") for prior Plan Years, a Rehabilitation Plan was adopted that was designed to have the Pension Plan emerge from the red zone within the time frame allowed by law.

This is to inform you that on November 29, 2022, the actuary for the Carpenters Pension Trust Fund for Northern California (the "Plan") certified to the U.S. Department of the Treasury and to the Board of Trustees, that the Plan remains in critical status (the "red zone") for the Plan Year beginning September 1, 2022. **The certification also notified the IRS that the Plan is making the scheduled progress in meeting the requirement of its Rehabilitation Plan.**

Although the Pension Plan remains in critical (red zone) status, because the Rehabilitation Plan continues to address long term funding issues, no new changes are required at this time.

Critical Status

According to provisions of the PPA, for the Plan Year beginning September 1, 2022, the Plan is labeled as being in critical status because the Plan has an accumulated funding deficiency within the next four Plan years.

Rehabilitation Plan

The Plan's actuary certified the Plan was in critical status for the first time for the Plan Year beginning September 1, 2009. Federal law requires that pension plans in critical status adopt a Rehabilitation Plan aimed at restoring the financial health of the plan. This is the fourteenth year the Plan has been in critical status. The law permits pension plans in critical status to reduce, or even eliminate, benefits called "adjustable benefits" as part of a Rehabilitation Plan. On July 27, 2010, the Board of Trustees adopted a Rehabilitation Plan consisting of two contribution rate/benefit schedules. All contributing employers and bargaining units adopted the Rehabilitation Plan's "Preferred Schedule" which does not require elimination or reduction in "adjustable benefits." To minimize the impact to participants and employers, it was anticipated that the adopted Rehabilitation Plan would address the long term funding issues over the full time frame allowed by law.

The Plan remains in critical status. At this time no further modification to the benefit levels under the Preferred Schedule of the Rehabilitation Plan have been made. The Plan is continuing to make scheduled progress in meeting the requirements of its Rehabilitation Plan.

If, in future years, the Trustees determine that future benefit reductions are necessary, you will receive a separate notice identifying and explaining the effect of those reductions. Any reduction of adjustable benefits (other than a repeal of a recent benefit increase) will not reduce the level of a participant's basic benefit payable at Normal Retirement Age.

Please be advised that whether or not the Plan reduces adjustable benefits in the future, the Plan has not been permitted to pay lump sum benefits (i.e., Level Income Option benefits) since it first provided Notice of Critical Status on December 23, 2009 and will not be permitted to do so while it continues to be in critical status.

Adjustable Benefits

During the rehabilitation period, the Plan continues to offer the following adjustable benefits:

- Disability Pension Benefits (if not yet in pay status);
- Service Pension Benefits;
- Early Retirement Pension Subsidies;
- 75% and 100% Joint-and-Survivor Pension;
- Pre-Retirement Death Benefit;
- 36 and 60 month Guarantee connected with Single-Life Pension.

If the existing Rehabilitation Plan has to be modified sometime in the future, adjustable benefits may be reduced or eliminated.

Employer Surcharge

The law requires that all contributing employers who have not agreed to a Collective Bargaining Agreement that implements the Rehabilitation Plan, pay to the Plan a surcharge to help correct the Plan's financial situation beginning 30 days after the employer is notified that the Plan is in critical status. If applicable, the surcharge would have been 5% of an employer's negotiated contribution rate applicable the first Plan Year in critical status (September 1, 2009 through August 31, 2010) and would have been increased to 10% beginning September 1, 2010 for each succeeding Plan year in which the Plan remains in critical status. **All contributing employers have agreed to a Collective Bargaining Agreement implementing the Rehabilitation Plan, therefore no surcharges have been assessed.**

What's Next

We understand that legally required notices like this one can create concern about the Plan's future. Be assured that the Board of Trustees takes very seriously its obligation to preserve the financial viability of the Plan and has been very proactive in addressing funding issues. Also, if you are currently retired and receiving a monthly benefit payment from the Pension Fund, your monthly check will continue uninterrupted.

With the assistance of the Plan's actuary, legal counsel and other professionals, and working with the contributing employers and the Union, the Trustees have developed a Rehabilitation Plan that addresses these issues. As a final note, since the Pension Plan is influenced by economic and financial variables beyond our control (such as market volatility and changes in employment and/or the number of contributing employers), unexpected developments can further affect the Plan's status and may require additional future corrective actions. Each year the Board of Trustees will review the Plan's progress with its professional advisors and adjust Plan rules as necessary to maintain the Plan's financial integrity.

Where To Get More Information

For more information about this notice or the Pension Plan in general, please contact the Trust Fund Office at the address or phone number below. You have a right to receive a copy of the Rehabilitation Plan from the Plan.

Carpenter Funds Administrative Office of Northern California, Inc.
265 Hegenberger Rd., Suite 100, Oakland, California 94621
Toll-Free: (888) 547-2054 or (510) 633-0333
benefitservices@carpenterfunds.com

As required by law, this notice is being provided to the Pension Benefit Guaranty Corporation (PBGC) and the Department of Labor (DOL).

CARPENTER FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA, INC.

carpenterfunds.com

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

December 21, 2022

TO: **All Participants, Beneficiaries, Participating Local Unions, and Contributing Employers**

FROM: **Board of Trustees**

RE: **Carpenters Pension Trust Fund for Northern California**
Annual Funding Notice – EIN #94-6050970
Plan Year: September 1, 2021 – August 31, 2022

Introduction

This notice, which is required by Federal law, includes important information about the funding status of your multiemployer Pension Plan (the "Plan"). It also includes general information about the benefit payments guaranteed by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. All traditional pension plans (called "defined benefit pension plans") must provide this notice every year regardless of their funding status. This notice does not mean that the Plan is terminating. It is provided for informational purposes and you are not required to respond in any way. This notice is for the Plan Year beginning September 1, 2021 and ending August 31, 2022 ("Plan Year").

How Well Funded Is Your Plan

The law requires the administrator of the Plan to tell you how well the Plan is funded, using a measure called the "funded percentage." The Plan divides its assets by its liabilities on the Valuation Date for the Plan Year to get this percentage. In general, the higher the percentage, the better funded the Plan. The Plan's funded percentage for the Plan Year and each of the two preceding Plan Years is shown in the chart below. The chart also states the value of the Plan's assets and liabilities for the same period.

Funded Percentage			
Valuation Date	2021 Plan Year as of September 1, 2021	2020 Plan Year as of September 1, 2020	2019 Plan Year as of September 1, 2019
Funded Percentage	83.7%	83.6%	79.3%
Value of Assets	$4,995,259,395	$4,502,646,134	$4,132,954,062
Value of Liabilities	$5,969,437,197	$5,383,101,772	$5,208,632,898

Year-End Fair Market Value of Assets

The asset values in the chart above are measured as of the Valuation Date. They also are "actuarial values." Actuarial values differ from market values in that they do not fluctuate daily based on changes in the stock or other markets. Actuarial values smooth out those fluctuations and can allow for more predictable levels of future contributions. Despite the fluctuations, market values tend to show a clearer picture of a plan's funded status at a given point in time. The asset values in the chart below are market values and are measured on the last day of the Plan Year. The chart also includes the year-end market value of the Plan's assets for each of the two preceding Plan Years.

Market Value of Assets			
	August 31, 2022[1]	August 31, 2021	August 31, 2020
Fair Market Value of Assets	$5,112,873,298	$ 5,469,802,769	$4,546,768,942

[1] Unaudited figure, subject to change.

Critical Status

Under federal pension law, a plan generally is in "critical" status if the funded percentage is less than 65 percent (other factors may also apply). If a pension plan enters critical status, the trustees of the plan are required to adopt a rehabilitation plan. Rehabilitation plans establish steps and benchmarks for pension plans to improve their funding status over a specified period of time.

The Plan was in "critical" status in the Plan Year ending August 31, 2022, because (1) the Plan had an accumulated funding deficiency for the current Plan Year, and (2) the Plan was in critical status the prior Plan Year and was projected to have an accumulated funding deficiency within the next ten Plan years, and (3) the Plan did not have a projected insolvency. This was the thirteenth year that the Plan was in critical status.

On November 25, 2009, for the Plan Year beginning September 1, 2009, the Plan's actuary certified the Plan to be in critical status for the first time. The Plan has continued to be certified to be in critical status for all Plan Years, including the Plan Year described in this Notice. Each year, all Participants, Beneficiaries, participating Employers, Local Unions, and the Pension Benefit Guaranty Corporation have been notified of the Plan's critical status, the requirement that the Board of Trustees adopt a "Rehabilitation Plan" and the possibility that certain types of adjustable benefits could be eliminated under the Rehabilitation Plan.

On July 27, 2010, as required by Federal law for pension plans in critical status, a Rehabilitation Plan consisting of two contribution rate/benefit schedules aimed at restoring the financial health of the Plan was adopted by the Board of Trustees. All contributing employers and bargaining units adopted the Rehabilitation Plan's "Preferred Schedule" which provided for a series of employer contribution increases and reductions in the future benefit accrual formula. However, no previously earned benefits or "adjustable benefits" were reduced or eliminated.

Annually, the Board of Trustees reviews and, if necessary, updates the Rehabilitation Plan. The Plan is continuing to make scheduled progress in meeting the requirements of its Rehabilitation Plan. Based on reasonable assumptions and the implemented Rehabilitation Plan, the Plan is currently projected to emerge from Critical Status by September 1, 2025.

You may get a copy of the Plan's Rehabilitation Plan, any updates to the Plan and the actuarial and financial data that demonstrate any action taken by the Plan toward fiscal improvement by contacting the Plan administrator.

If the Plan is in endangered, critical, or critical and declining status for the Plan Year ending August 31, 2023, separate notification of that status will be provided.

Participant Information

The total number of participants in the Plan as of the Plan's valuation date was 50,584. Of this number, 21,206 were active participant, 18,913 were retired or separated from service and receiving benefits, and 10,465 were retired or separated from service and entitled to future benefits.

Funding & Investment Policies

Every pension plan must have a procedure to establish a funding policy for plan objectives. A funding policy relates to how much money is needed to pay promised benefits. The funding policy of the Plan is based on collective bargaining agreements that provide for employer contributions on an agreed-upon cents-per-hour basis. There are no employee contributions.

Pension plans also have investment policies. These generally are written guidelines or general instructions for making investment management decisions. The investment policy of the Plan is to invest in a manner consistent with the fiduciary standards of ERISA, namely (1) to undertake all transactions in the sole interest of Plan Participants and Beneficiaries, (2) to provide benefits and defray reasonable expenses of Plan administration in a prudent manner, and (3) to diversify assets. All investments shall be made in compliance with relevant laws and the Trust Agreement governing the Trust.

Under the Plan's investment policy, the Plan's assets were allocated among the following categories of investments, as of the end of the Plan Year. These allocations are percentages of total assets:

Allocation of Investments – Year End August 31, 2022	
Interest-bearing cash	0.21%
U.S. Government Securities	1.71%
Corporate Debt Instruments • Preferred • All Others	13.52%
Corporate Stocks • Preferred • Common	17.5%
Partnership/Joint Venture Interests	17.84%
Real Estate	0.40%
Loans (Other than to Participants)	0.62%
Value of Interest in Common/Collective Trusts	32.32%
Value of Interest in Pooled Separate Accounts	1.31%
Value of Interest in 103-12 Investment Entities	4.82%
Other	9.75%
TOTAL	100.00%

For information about the Plan's investment in any of the following types of investments, common/collective trusts, pooled separate accounts, or 103-12 investment entities – contact:

Carpenter Funds Administrative Office of Northern California, Inc.
265 Hegenberger Rd. Suite 100, Oakland, California 94621
Toll-Free: (888) 547-2054 or (510) 633-0333
benefitservices@carpenterfunds.com

Events Having a Material Effect on Assets or Liabilities

By law this notice must contain a written explanation of new events that have a material effect on plan liabilities or assets. This is because such events can significantly impact the funding condition of a plan. For the Plan Year beginning on September 1, 2022 and ending on August 31, 2023, the Plan does not expect there to be any such events.

Right to Request a Copy of the Annual Report

Pension plans must file annual reports with the U.S. Department of Labor. The report is called the "Form 5500." These reports contain financial and other information. You may obtain an electronic copy of your Plan's annual report by going to www.efast.dol.gov and using the search tool. Annual reports also are available from the U.S. Department of Labor, Employee Benefits Security Administration's Public Disclosure Room at 200 Constitution Avenue, Rm N-1513, Washington DC 20210, or by calling 202-693-8673. Or you may obtain a copy of the Plan's annual report by making a written request to the plan administrator. A copy of the Annual Report will not be available until June 2023.

Annual reports do not contain personal information, such as the amount of your accrued benefit. You may contact your Plan administrator if you want information about your accrued benefits. Your Plan administrator is identified below under "Where to Get More Information."

Summary of Rules Governing Insolvent Plans

Federal law has a number of special rules that apply to financially troubled multiemployer plans that become insolvent, either as ongoing plans or plans terminated by mass withdrawal. The plan administrator is required by law to include a summary of these rules in the annual funding notice. A plan is insolvent for a plan year if its available financial resources are not sufficient to pay benefits when due for the plan year. An insolvent plan must reduce benefit payments to the highest level that can be paid from the plan's available resources. If such resources are not enough to pay benefits at the level specified by law (see "Benefit Payments Guaranteed by the PBGC" below), the plan must apply to the PBGC for financial assistance. The PBGC will loan the plan the amount necessary to pay benefits at the guaranteed level. Reduced benefits may be restored if the plan's financial condition improves.

A plan that becomes insolvent must provide prompt notice of its status to participants and beneficiaries, contributing employers, labor unions representing participants, and PBGC. In addition, participants and beneficiaries also must receive information regarding whether, and how, their benefits will be reduced or affected, including loss of a lump sum option.

Benefit Payments Guaranteed by the PBGC

The maximum benefit that the PBGC guarantees is set by law. Only benefits that you have earned a right to receive and that cannot be forfeited (called vested benefits) are guaranteed. There are separate insurance programs with different benefit guarantees and other provisions for single-employer plans and multiemployer plans. Your Plan is covered by PBGC's multiemployer program. Specifically, the PBGC guarantees a monthly benefit payment equal to 100 percent of the first $11 of the Plan's monthly benefit accrual rate, plus 75 percent of the next $33 of the accrual rate, times each year of credited service. The PBGC's maximum guarantee, therefore, is $35.75 per month times a participant's years of credited service.

Example 1: If a participant with 10 years of credited service has an accrued monthly benefit of $600, the accrual rate for purposes of determining the PBGC guarantee would be determined by dividing the monthly benefit by the participant's years of service ($600/10), which equals $60. The guaranteed amount for a $60 monthly accrual rate is equal to the sum of $11 plus $24.75 (.75 x $33), or 35.75. Thus, the participant's guaranteed monthly benefit is $357.50 ($35.75 x 10).

Example 2: If the participant in Example 1 has an accrued monthly benefit of $200, the accrual rate for purposes of determining the guarantee would be $20 (or $200/10). The guaranteed amount for a $20 monthly accrual rate is equal to the sum of $11 plus $6.75 (.75 x $9), or $17.75. Thus, the participant's guaranteed monthly benefit would be $177.50 (17.75 x 10).

The PBGC guarantees pension benefits payable at normal retirement age and some early retirement benefits. In addition, the PBGC guarantees qualified preretirement survivor benefits (which are preretirement death benefits payable to the surviving spouse of a participant who dies before starting to receive benefit payments). In calculating a person's monthly payment, the PBGC will disregard any benefit increases that were made under a plan within 60 months before the earlier of the plan's termination or insolvency (or benefits that were in effect for less than 60 months at the time of termination or insolvency). Similarly, the PBGC does not guarantee benefits above the normal retirement benefit, disability benefits not in pay status, or non-pension benefits, such as health insurance, life insurance, death benefits, vacation pay, or severance pay.

For additional information about the PBGC and the pension insurance program guarantees, go to the Multiemployer Page on PBGC's website at www.pbgc.gov/multiemployer. Please contact your employer or plan administrator for specific information about your Pension Plan or Pension Benefit. PBGC does not have that information. See "Where to Get More Information About Your Plan," below.

Where to Get More Information

For more information about this notice, or the Pension Plan in general, please contact the Trust Fund Office at:

Carpenter Funds Administrative Office of Northern California, Inc.
265 Hegenberger Rd., Suite 100, Oakland, California 94621
Toll-Free: (888) 547-2054 or (510) 633-0333
benefitservices@carpenterfunds.com

For identification purposes, the official Plan number is 001 and the Plan's employer identification number or "EIN" is 94-6050970. For more information about the PBGC and benefit guarantees, go to the PBGC's website, ww.pbgc.gov, or call PBGC toll-free at 1(800) 400-7242 (TTY/TDD users may call the Federal Relay Service toll free at 1(800) 877-8339 and ask to be connected to 1(800) 400-7242).

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
www.carpenterfunds.com

January 27, 2023

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: **Plan Changes**
- **Improved Member Assistance Program – Effective 1/1/2023**
- **Allowed Amount Increase – Effective 11/1/2022**
- **No Surprises Act – Effective 9/1/2022**

This Participant Notice advises you of material modifications made to your medical benefits. This information is important to you and your Dependents. Please take the time to read it carefully.

Member Assistance Program (MAP)

Improvements to MAP Benefits for Counseling Visits

Beginning January 1, 2023, the number of free counseling visits increases from four (4) visits to six (6) visits for each personal situation.

Your MAP benefits provide services such as counseling visits, articles and podcasts, and online seminars for a wide variety of needs, including:

- crisis counseling
- relationship counseling
- legal assistance
- financial advice and identity protection
- tobacco cessation coaching
- other work-life services

All Plan enrollees, regardless of which medical plan option you are enrolled in (Indemnity or Kaiser) have access to MAP services. All MAP benefits are free of charge for you to use. For more information or to use MAP services, please contact Anthem MAP at (800) 999-7222 or visit the website at www.anthemeap.com and enter the code: Carpenters Trust.

Indemnity Plan Allowed Amount

The Indemnity Health Plan has a Medicare-based reimbursement strategy for Providers who do not have PPO contracts with Anthem Blue Cross (Non-Contract Providers). In addition, the Plan has a specific Allowed Amount for physician and other health care practitioners when the Provider does not have a PPO Contract with Anthem Blue Cross and is not registered with the Centers for Medicare and Medicaid Services (CMS).

Effective November 1, 2022, the Allowed Amount was increased to $200 for each visit with a Non-Contract and Non-CMS registered Provider. Prior to November 1, 2022 the Allowed Amount was $100 for each visit.

No Surprises Act

Indemnity Plan Benefits Improvements for Certain Services from Non-Contract Providers

The No Surprises Act, signed into law in December 2020, protects patients who receive Emergency Services at a hospital or an Independent Freestanding Emergency Department or Air Ambulance Services. This law also protects patients who receive non-emergency services from a Non-Contract Provider at an in-network (Contract) facility.[1] Effective September 1, 2022, participants and dependents receiving these services will only be responsible for paying their in-network Cost-Sharing requirement, and cannot be Balance Billed by the provider or facility for these services.

If you have elected to enroll in the Kaiser HMO Plan, information about the No Surprises Act will be included in the Evidence of Coverage issued by Kaiser Permanente.

Effective for services on or after September 1, 2022, the Fund is implementing a number of improvements to the Indemnity Plan to comply with the No Surprises Act, including:

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a Contract provider or a Contract emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Contract providers and Contract emergency facilities;
- At the Contracted coinsurance when received from either a Contract or Non-Contract Provider;
- By calculating the Cost-Sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any Cost-Sharing payments made by the Participant or beneficiary with respect to the Emergency Services toward any Contract deductible or Contract Coinsurance Maximum applied under the Plan regardless of whether Emergency Services are furnished by a Contract provider or Non-Contract emergency facility.

1 The federal law does not apply for non-emergency services from a Non-Contract Provider at an in-network facility if the Non-Contract Provider meets certain notice and consent requirements for such services.

In general, you cannot be Balance Billed for these items or services. Your Cost-Sharing amount for Emergency Services from Non-Contract Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (QPA).

For example, you received Emergency Services at a Non-Contact facility and you've already met your deductible. The billed charge is $2,000. However, the Qualified Payment Amount (QPA) for those services is $1,000. As a Participant in Carpenter Funds Indemnity Plan A/R, Emergency Services are covered at 90% (after your deductible is satisfied).

Therefore, your Cost-Sharing responsibility will be only $100 – 10% coinsurance of the $1,000 QPA.

You cannot be Balance Billed, nor will you have to pay a higher Non-Contract coinsurance. Your entire Cost-Sharing responsibility in our example is $100.

Non-Emergency Items or Services from a Non-Contract Provider at a Contract Facility

With regard to Covered non-emergency items or services performed by a Non-Contract Provider at a Contract facility, these items or services are covered by the Plan:

- With a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the items or services had been furnished by a Contract provider;
- By calculating the Cost-Sharing requirements as if the total amount that would have been charged for the items and services by such Contract provider were equal to the Recognized Amount for the items and services;
- By counting any Cost-Sharing payments made by the Participant or beneficiary toward any Contract deductible and Contract coinsurance maximum applied under the Plan regardless of whether such Cost-Sharing payments were made with respect to items and services furnished by a Contract or Non-Contract provider.

In general, you cannot be Balance Billed for these items or services. Your Cost-Sharing amount for non-emergency services performed at a Contract facility from Non-Contract Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (QPA).

Non-emergency items or services performed by a Non-Contract Provider at a Contract facility will be covered based on the Plan's definition of Allowed Charge and forgo the financial protections of the No Surprises Act if:

1. At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment) the Participant or dependent is supplied with:
    - written notice that the provider is a Non-Contract Provider with respect to the Plan,
    - an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment,
    - the names of any Contract providers at the facility who are able to treat the patient, and informed that the patient may elect to be referred to one of the Contract providers listed; and
2. The Participant or dependent gives informed consent to continued treatment by the Non-Contract Provider, acknowledging that the Participant or beneficiary understands that continued treatment by the Non-Contract Provider may result in greater cost to the Participant or beneficiary.

The notice and consent exception for non-emergency items or services provided by a Non-Contract Provider at a Contract facility does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Contract Provider satisfied the notice and consent criteria, and therefore these services will be covered as follows:

- With a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the items or services had been furnished by a Contract provider;
- With Cost-Sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services;
- With Cost-Sharing for items and services so furnished counted toward any in-network deductible and in-network coinsurance maximums, as if such Cost-Sharing payments were made for items and services furnished by a Contract provider.

In general, you cannot be Balance Billed for these items or services. The Cost-Sharing Amount for non-emergency services at Contract Facilities by Non-Contract Providers will based on the Recognized Amount, which is, generally, the lesser of the billed charges from the Non-Contract Provider or the Qualifying Payment Amount (i.e., the Plan's median of contracted rates for the item or service in that location).

Air Ambulance Services

If you receive Air Ambulance Services from a Non-Contract Provider that are otherwise covered by the Plan, those services will be covered by the Plan as follows:

- Air Ambulance Services received from a Non-Contract Provider will be covered with a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the services had been furnished by a Contract provider;
- Your Cost-Sharing Amount will be calculated as if the total amount that would have been charged for the services by a Contract provider of Air Ambulance Services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services;
- Any Cost-Sharing payments you make with respect to covered Air Ambulance Services will count toward your Contract deductible and Contract coinsurance maximum in the same manner as if those services were received from a Contract provider.

In general, you cannot be Balance Billed for these items or services.

Payments to Non-Contract Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at Contract Facilities by Non-Contract Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-Contract Provider or Air Ambulance Service provider. The 30-day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the Participant cannot be required to pay more than the Cost-Sharing Amount under the Plan, and the provider or facility is prohibited from billing the Participant or dependent in excess of the required Cost-Sharing Amount.

The Plan will pay a total Plan payment directly to the Non-Contract Provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the Cost-Sharing Amount for the services, less any initial payment amount.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Contract provider or facility terminates, or your benefits terminate under the Plan because of a change in terms of the providers' and/or facilities' participation in the Plan:

- You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
- You will be allowed up to ninety (90) days of continued coverage at the Contract Cost-Sharing Amount to allow for a transition of care to a Contract provider.

Incorrect Contract Provider Information

A list of Contract providers is available to you without charge on the website (www.anthem.com) or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information provided by the Plan about whether a provider is a Contract provider from the Plan or its administrators, the Plan will apply the Contract Cost-Sharing Amount to your claim, even if the provider was a Non-Contract Provider when the service were received.

Complaint Process

If you believe you've been billed incorrectly, or otherwise have a complaint under the No Surprises Act, contact the Trust Fund Office.

EXTERNAL REVIEW OF CERTAIN COVERAGE DETERMINATIONS

Effective September 1, 2022

If your initial claim for benefits related to an Emergency Service, Non-Emergency Service provided by a Non-Contract Provider at a Contract facility, and/or Air Ambulances service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Fund Office for a copy of the Fund's External Review procedures.

PATIENT PROTECTIONS

Effective September 1, 2022

The Indemnity Plan does not require the selection or designation of a primary care provider (PCP) or pediatrician. You have the ability to visit any Contract or Non-Contract Health Care Provider; however, payment by the Plan may be less for the use of a Non-Contract Provider.

You do not need prior authorization from the Fund, Anthem Blue Cross, or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network 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 Anthem Blue Cross at www.anthem.com or call the Fund Office at (888) 547-2054.

NEW/REVISED DEFINITIONS OF THE PLAN

Effective September 1, 2022

To implement the protections of the No Surprises Act, effective September 1, 2022, the Fund is adopting the following new/revised definitions of terms in the Plan.

Air Ambulance Service means medical transport for patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605.

The definition of "Allowed Charge" is Amended and modified as follows:

Allowed Charge/Allowed Amount/Allowable Charge means:

a. For Emergency Services provided by Non-Contract Providers, Non-Emergency Services provided by a Non-Contract provider at a Contract facility, and for Air Ambulance Services, the Out-of-Network Rate, as defined below**.**

b. For all other services, the lesser of:

(1) The dollar amount this Plan has determined it will allow for covered Medically Necessary services or supplies provided by Non-Contract Providers as determined by the Plan's Preferred Provider Organization based on appropriate and reasonable charges for the services in the geographical area where the services are provided. With respect to Non-Contract Hospitals or Facilities within the Contract Provider service area for other than Emergency Services, the Allowed Charge will be the negotiated contract rate of the Contract Hospital or Facility that is geographically nearest to the Hospital or Facility where treatment was received. The Plan's Allowed Charge is not based on or intended to be reflective of fees that have traditionally been described as usual and customary (U&C), usual, customary and reasonable (UCR) or any other traditional term. Non-Contract Providers' bills often exceed the Plan's Allowed Charge, and in such cases the Plan's benefits will be based on the Allowed Charge not the Non-Contract Providers billed rate except as provided for Emergency Services provided by Non-Contract Providers, for Non-Emergency Services provided by a Non-Contract provider at a Contract facility, and for Air Ambulance services. When using Non-Contract Providers, the Eligible Individual is responsible for any difference between the actual billed charge and the Plan's Allowed Charge, in addition to any copay and coinsurance required by the Plan.

(2) The Non-Contract Provider's actual billed charge.

Ancillary Services are, with respect to a Contract Health Care Facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, and subject to designated exceptions specified; and
- Items and services provided by a Non-Contract Provider if there is no Contract Provider who can furnish such item or service at such facility.

The definition of "Balance Billing" is Amended and modified as follows:

Balance Billing/Billed is a bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with Balance Billing are not covered by this Plan, even if the Plan's Coinsurance Maximum limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's Coinsurance Maximum and may result in Balance Billing to you. **Non-Contract Providers commonly engage in Balance Billing.** This means a Plan Participant may be billed for any balance that may be due in addition to the amount payable by the Plan. **Generally, you can avoid Balance Billing by using Contract Providers**.

Pursuant to the No Surprises Act, you may not be Balance Billed for Emergency Services, Air Ambulance Services, and, unless appropriate notice and consent criteria are met, Non-Emergency Services performed by non-participating providers at a participating facility. For these services, Cost-Sharing payments shall count toward any in-network deductible and in-network coinsurance maximum.

Continuing Care Patient means an individual who, with respect to a provider or facility—

- Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Cost-Sharing means the amount a Participant or beneficiary is responsible for paying for a covered item or service under the terms of the Plan. Cost-Sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, Balance Billing by Non-Contract Providers, or the cost of items or services that are not covered under the Plan.

The **Cost-Sharing Amount** for Emergency and Non-Emergency Services at Contract Facilities performed by Non-Contract Providers, and Air Ambulance Services from Non-Contract Providers will be based on the Recognized Amount.

The definition of "Emergency (Qualified)" is Amended and modified as follows:

Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Services means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-Contract Provider or Non-Contract Emergency Facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (i.e., items and services provided after the patient is stabilized) as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services were furnished until:

- The attending emergency physician or treating provider determines that the Participant or beneficiary is able to travel a reasonable distance using nonmedical transportation or nonemergency medical transportation; and
- The Participant or beneficiary is supplied with a written notice of the following:
    a. The provider is a Non-Contract Provider with respect to the Plan,
    b. An estimate of the charges for treatment and any advance limitations that the Plan may put on your treatment,
    c. The names of any Contract Providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the Contract Providers listed; and
    d. The patient (or their authorized representative) gives informed voluntary consent to continued treatment by the Non-Contract Provider, acknowledging that the patient (or their authorized representative) understands that continued treatment by the Non-Contract Provider may result in greater cost to the Participant or beneficiary.

Health Care Facility (for non-emergency services) is each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Independent Freestanding Emergency Department is a Health Care Facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

No Surprises Act means the No Surprises Act (Public Law 116-260, Division BB).

Non-Contract Emergency Facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the Plan or coverage.

Non-Contract Provider means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to furnishing of an item or service under the Plan.

Out-of-Network Rate: With respect to Emergency Services provided by a Non-Contract Provider, non-emergency services furnished by a Non-Contract Provider at a Contract Facility, and Air Ambulance Services by a Non-Contract Provider, **Out-of-Network Rate** means one of the following:

- The amount the parties negotiate;
- The amount approved under the independent dispute resolution (IDR) process; or
- If the state has an All-Payer Model Agreement, the amount that the state approves under that system.

Out-of-Pocket Maximum or Limit: The No Surprises Act modifies the definition of Coinsurance Maximum, an Out-of-Pocket Limit, provided in the Summary Plan Description for Emergency Services, non-emergency services furnished by a Non-Contract Provider at a Contract Facility, and Air Ambulance Services. Any Cost-Sharing payments (e.g., copayments, *coinsurance*, and deductible) made by the Participant or beneficiary are counted towards any in-network deductible or Out-of-Pocket Limit.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the Plan or issuer for the item or service in the area.

Recognized Amount means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

For Air Ambulance Services furnished by Non-Contract Providers, the **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Serious and Complex Condition means with respect to a Participant, beneficiary, or enrollee under the Plan one of the following:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent;
- In the case of a chronic illness or condition, a condition that is—
    a. Life-threatening, degenerative, potentially disabling, or congenital; and
    b. Requires specialized medical care over a prolonged period of time.

Termination: In the context of Continuity of Care, **Termination** includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. You may also call the Plan's Administrative Office at (510) 633-0333 or Toll Free at (888) 547-2054.

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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.