

**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**

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*Esta noticia es disponible en español 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.

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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](http://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

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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.

# 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.

**C** Online Services

Username:

Password:

Login

Username and Password help.

Start your online account.

Register Today

**A** Find a Dentist

**B** Select Network:

Delta Dental PPO

Dentist, Practice or Keyword:

Name, Practice...

Search

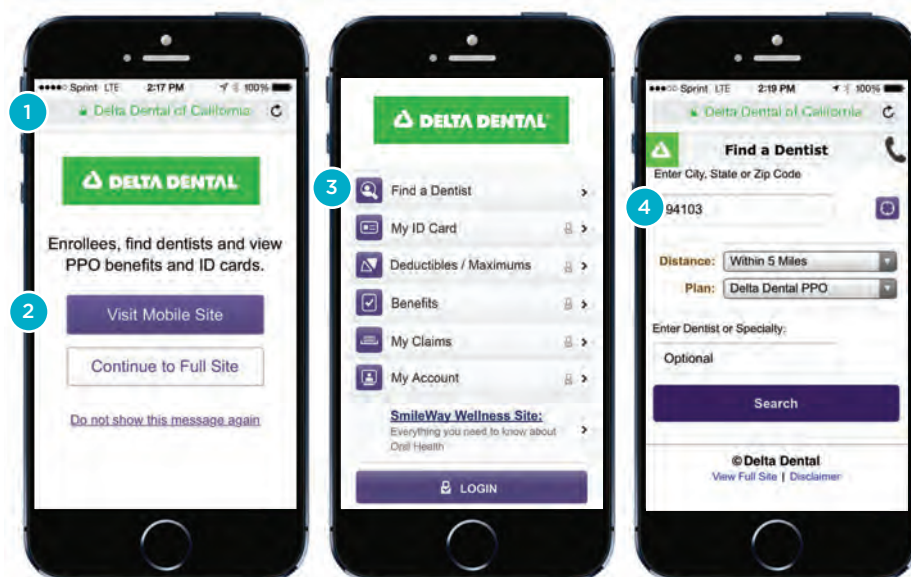


## MOBILE APP<sup>1</sup>:

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<sup>1</sup>:

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**.

<sup>1</sup> Some features available to PPO and Premier enrollees only.

Delta Dental Premier and Delta Dental PPO are underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV, TX and UT and by not-for-profit dental service companies in these states: CA - Delta Dental of California; PA, MD - Delta Dental of Pennsylvania; NY - Delta Dental of New York, Inc.; DE - Delta Dental of Delaware, Inc.; WV - Delta Dental of West Virginia, Inc. In Texas, Delta Dental PPO is underwritten as a dental provider organization (DPO) plan.

DeltaCare USA is underwritten in these states by these entities: AL - Alpha Dental of Alabama, Inc.; AZ - Alpha Dental of Arizona, Inc.; CA - Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY - Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV - Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX - Alpha Dental Programs, Inc.; NV - Alpha Dental of Nevada, Inc.; UT - Alpha Dental of Utah, Inc.; NM - Alpha Dental of New Mexico, Inc.; NY - Delta Dental of New York, Inc.; PA - Delta Dental of Pennsylvania; VA - Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Delta Dental of California, Delta Dental of New York, Inc., Delta Dental of Pennsylvania, Delta Dental Insurance Company and our affiliated companies form one of the nation's largest dental benefits delivery systems, covering 34.5 million enrollees. All of our companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 74 million people in the U.S.

**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.anthemmap.com](http://www.anthemmap.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.<sup>1</sup> 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.

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<sup>1</sup> 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-Contract 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 be 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](http://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](http://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.

\* \* \* \* \*

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](http://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](mailto:benefitservices@carpenterfunds.com). Forms and information can be found on our website at [www.carpenterfunds.com](http://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

May 30, 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**

- **Orthodontic Claims to be paid by Delta Dental**
- **Improvements to Indemnity Plan Benefits**
- **End of the Public Health Emergency (PHE)**

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

**Orthodontic Claims for Children**  
**(Applies only to Dependents covered under the Active Plan)**

At this time, Orthodontic benefits are payable at the Trust Fund Office. Orthodontic benefits are payable at 50% of Allowed Charges and are paid in one lump sum, up to \$1,500 (lifetime maximum) per Dependent child under the age of 19.

**Beginning for services on or after July 1, 2023**, orthodontic benefits will remain the same as above; however, benefits will be paid by Delta Dental instead of at the Trust Fund Office.

Submit your Dependent children's orthodontic claims to:

Delta Dental Plan of California  
P.O. Box 997330  
Sacramento, CA 95899-7330

**Improvements to Indemnity Plan Benefits**

The Board of Trustees has made the following changes and/or clarifications to your benefits effective for services received on or after July 1, 2023:

- **Maximum Allowable Charge for single hip replacement or single knee replacement:** The Fund has increased the maximum benefit of \$30,000 for a single hip replacement or a single knee joint replacement surgery performed at a hospital (whether inpatient or outpatient) from \$30,000 to \$35,000 for surgeries on or after July 1, 2023. **Maximums will not apply to a single hip replacement or a single knee joint replacement done in an outpatient surgical center.** A list of in-network PPO outpatient surgical centers can be found at: <https://www.anthem.com/find-care/>

- **Smoking cessation:** The Board amended the Plan to allow counseling and interventions for tobacco use (both smoking and chewing tobacco) as follows:
  - screening for tobacco use; and,
  - for tobacco users, at least two (2) tobacco cessation attempts per year. Each “tobacco cessation attempt” includes coverage for:
    - **four (4) tobacco cessation counseling sessions** of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
    - all **FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications)** for a 90-day treatment regimen when prescribed by a health care provider
- **Hospice Benefits:** Hospice benefits were inadvertently omitted from the Rules and Regulations of the Plan in error. To clarify, hospice benefits are available as follows:

If an Eligible Individual is terminally ill, with a life expectancy of 6 months or less, benefits are payable for hospice care provided by an Approved Hospice Program. Covered Services must be prescribed by a Physician and will include nursing services by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), Medical social services by a person with a Master’s degree in social work, Home health aide, medical supplies normally used by Hospital inpatients and dispensed by the hospice agency, nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation and respite care, not to exceed 8 days. Covered benefits will not include transportation, services of volunteers, food, clothing or housing, services provided by household members, family or friends or services of financial or legal counselors.

- **Autism:** Beginning for services on or after July 1, 2023, the Fund will provide coverage for Applied Behavioral Therapy (ABA) in accordance with Anthem guidelines. In addition, there will be coverage available for physical, occupational and speech therapy (even if habilitative in nature) if the therapy is being done as part of an approved autism plan.

#### **Clarifications of Medical Benefits for COVID-19 Services Effective May 12, 2023**

This Notice clarifies important changes in COVID-19 related benefits and administrative deadlines as a result of the declared end of the National Emergency (“NE”) and Public Health Emergency (“PHE”) on May 11, 2023.

The federal government has announced that both the National Emergency (NE) and Public Health Emergency (PHE) related to COVID-19 terminated on May 11, 2023. Consequently, the plan rules concerning coverage of certain benefits related to COVID-19 will be changing. In general, special rules in effect during the emergency will terminate and benefits will be covered under the usual cost-sharing provisions of the Welfare Fund.

#### **Changes to COVID-19 Related Benefits**

Below is a brief summary of changes to COVID-19 related medical and prescription drug coverage beginning May 12, 2023:

Benefit	During the Emergency Period	Effective May 12, 2023
<b>COVID-19 vaccines, including boosters</b>	No charge for the vaccine when received at either in-network or out-of-network providers.	<ul style="list-style-type: none"> <li>• <b>Contract Provider:</b> Deductible does not apply, payable at 100%</li> <li>• <b>Non-Contract Provider:</b> Not covered.</li> </ul>
<b>COVID-19 diagnostic tests and related services</b>	No charge for COVID-19 test related office visits or lab tests (including rapid diagnostic and swab-and-send tests) performed by either in-network or out-of-network providers.	COVID-19 test related office visits or lab tests will be covered in the same manner and at the same shared cost as any test or lab, based on whether the service is performed with a Contracted or Non-Contracted Provider registered with CMS.
<b>COVID-19 at-home test kits, also known as over-the-counter, or OTC test kits</b>	No charge for up to eight (8) over-the-counter (OTC) COVID-19 tests per month, both in and out-of-network. Reimbursement for out-of-network OTC COVID-19 tests is limited to \$12 per test.	COVID-19 OTC tests are not covered under the plan and are not reimbursable.

### Elimination of Extended Deadlines for Administrative Actions

In addition to the changes above, there are also certain administrative timeframes that will return to normal after the end of the NE and PHE.

Below is a brief summary of changes to administrative related deadlines beginning the earlier of 60 days after the announced end of the COVID-19 National Health Emergency, July 10, 2023, or one year from the deadline for your particular deadline, whichever is earlier.

Administrative Timeframe	During the Emergency Period	Return to Normal Timeframes
<b>COBRA, HIPAA, special enrollment and benefit claims and appeals</b>	<p>During the National Emergency, deadlines were extended until the earlier of July 10, 2023, or one year from the original due date for:</p> <ul style="list-style-type: none"> <li>✓ COBRA elections</li> <li>✓ Paying COBRA premiums</li> <li>✓ Electing HIPAA special enrollment</li> <li>✓ Filing claims, appeals and requests for external review</li> </ul>	<p>Beginning on and after July 10, 2023, these deadlines return to their normal timeframes and due dates.</p> <p>Please see your Summary Plan Description or contact the Fund Office for details on applicable timeframes.</p>

You are still encouraged to use Contracted facilities and Contracted providers whenever possible. Please keep this important notice with your SPD/Rules and Regulations for easy reference to all Plan provisions. Please review these changes carefully and contact the Fund Office with any questions that you may have.

\* \* \* \* \*

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](http://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](mailto:benefitservices@carpenterfunds.com). Forms and information can be found on our website at [www.carpenterfunds.com](http://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.*





## CARPENTER FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA, INC.

[carpenterfunds.com](http://carpenterfunds.com)

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

July 2023

**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](mailto: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](http://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](http://www.carpenterfunds.com) or call 1-888-547-2054 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Contract <u>Provider</u> : \$128/individual per calendar year; \$256/family per calendar year. Non-Contract <u>Provider</u> : \$257/person per calendar year; \$514/family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Mental health, chemical dependency (including detox), member assistance program visits, Contract <u>Provider</u> On-line physician visits up to \$49 per visit, and outpatient <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	There is no <u>out-of-pocket limit</u> on all types of <u>cost sharing</u> , but there is a \$6,445/person (\$12,890/family) on the amount of <u>coinsurance</u> that you must pay for covered services in a year.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, hearing examination and hearing aid expenses, penalties for failure to obtain precertification, <u>deductibles</u> , expenses from Non-Contract <u>providers</u> , outpatient retail/mail order <u>prescription drug</u> expenses, amounts over the reference-based pricing allowances and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-888-547-2054 for a list of Contract <u>providers</u> in California. See <a href="http://www.bcbs.com">www.bcbs.com</a> or call 1-800-810-2583 for a list of Contract <u>providers</u> outside the state of California.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment.</li> <li>Plan pays 100% for physician online visits with a Contract <u>provider</u>.</li> </ul>
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment.
	<u>Preventive care/screening/Immunization</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>For adults and children, benefits are limited to one routine physical exam in any 12-month period.</li> <li>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.</li> <li>No charge for COVID-19 vaccine and <u>deductible</u> does not apply from a Contract <u>Provider</u>. No coverage from a Non-Contract <u>provider</u>.</li> <li>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.</li> <li>Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment.</li> </ul>
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Professional/physician charges may be billed separately (Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment). Precertification is required for CT/CTA, MRI, Nuclear Cardiology, Pet Scans and Echocardiography.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call 1-800-939-7093.	Generic drugs	Retail: \$15 <u>copay</u> /fill. Mail order: \$26 <u>copay</u> /fill	You pay 100% (unless there are no <u>network</u> pharmacies within 10 miles). <u>Plan</u> reimburses no more than it would have paid had you used an In- <u>Network</u> Retail pharmacy.	<ul style="list-style-type: none"> <li>• Retail Pharmacy – 30-day supply</li> <li>• Mail Order Pharmacy – 90-day supply</li> <li>• <u>Deductible</u> does not apply to outpatient <u>prescription drugs</u>.</li> <li>• <u>Cost sharing</u> for outpatient <u>prescription drugs</u> <b>does not count</b> toward the <u>out-of-pocket limit</u>.</li> <li>• If the cost of the drug is less than the <u>copay</u>, you pay just the drug cost.</li> <li>• Some <u>prescription drugs</u> are subject to <u>preauthorization</u> (to avoid non-payment), or step therapy requirements.</li> <li>• Brand name Proton Pump Inhibitors (PPI) and Cholesterol drugs not covered.</li> <li>• For any new Brand Name Drug approved by the federal FDA, including injectable and infusion drugs, the <u>copay</u> 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 <u>copay</u> will remain at 50% of the cost of the drug.</li> <li>• Mail Order is mandatory if more than 2 prescriptions are filled for maintenance medications.</li> </ul>
	Preferred brand drugs ( <u>Formulary</u> brand drugs)	Retail: \$15 <u>copay</u> /fill + cost difference between generic and brand for multi-source brand. \$53 <u>copay</u> /fill for single-source <u>formulary</u> brand. Mail order: \$26 <u>copay</u> /fill + cost difference between generic and brand for multi-source brand. \$106 <u>copay</u> /fill for single-source <u>formulary</u> brand.		
	Non-preferred brand drugs ( <u>Non-formulary</u> brand drugs)	Retail: \$80 <u>copay</u> /fill; Mail Order: \$133 <u>copay</u> /fill		
	<u>Specialty drugs</u>	Subject to Retail <u>Copays</u> (30-day supply).	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u> plus any amounts over \$300	For certain outpatient surgeries, the <u>Plan</u> has a maximum benefit payable if services are done at a hospital facility instead of an ambulatory surgery center. To avoid <u>Plan</u> maximums, precertification is required for outpatient surgeries.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/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	<u>Emergency room care</u>	<b>Medical:</b> 20% <u>coinsurance</u> . <b>Mental Health or Substance Abuse:</b> No charge	<b>Medical:</b> 40% <u>coinsurance</u> (20% <u>coinsurance</u> if no choice in hospital due to emergency). <b>Mental Health or Substance Abuse:</b> No charge	Professional/physician charges may be billed separately. (Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment).
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> .	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 <u>Plan</u> Document for more information on emergency care.
	<u>Urgent care</u>	<b>Medical:</b> 20% <u>coinsurance</u> . <b>Mental Health or Substance Abuse:</b> No charge	<b>Medical:</b> 40% <u>coinsurance</u> (20% <u>coinsurance</u> if no choice in hospital due to emergency). <b>Mental Health or Substance Abuse:</b> No charge	Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Precertification is required.</li> <li>A maximum of \$35,000 is payable for the hospital facility charges associated with a single hip joint or knee joint replacement surgery.</li> <li>In a Non-Contract Hospital, the <u>plan</u> 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).</li> <li>Services from Non-Contract <u>providers</u> not registered with CMS are not covered.</li> </ul>
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Services from Non-Contract <u>providers</u> not registered with CMS are not covered.

\* For more information about limitations and exceptions, see the Plan or policy document at [www.carpenterfunds.com](http://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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	<b>Mental Health:</b> Office visit: No charge, <u>deductible</u> does not apply. Other outpatient services: 20% <u>coinsurance</u> , <u>deductible</u> does not apply. <b>Substance Abuse:</b> no charge, <u>deductible</u> does not apply	40% <u>coinsurance</u> , <u>deductible</u> does not apply.	<ul style="list-style-type: none"> <li>Plan pays 100% for physician online visits with a Contract <u>provider</u>.</li> <li>Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment.</li> </ul>
	Inpatient services	<b>Mental Health:</b> 20% <u>coinsurance</u> , <u>deductible</u> does not apply. <b>Substance Abuse:</b> no charge, <u>deductible</u> does not apply.	40% <u>coinsurance</u> , <u>deductible</u> does not apply.	<ul style="list-style-type: none"> <li>Precertification is required.</li> <li>In a Non-Contract Hospital, the <u>plan</u> 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)</li> <li>Services from Non-Contract <u>providers</u> not registered with CMS are not covered.</li> </ul>
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).</li> <li>Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment</li> </ul>
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Services from Non-Contract <u>providers</u> not registered with CMS are not covered.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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 <u>providers</u> not registered with CMS are not covered.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<b>Outpatient:</b> Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment. <b>Inpatient:</b> Services from Non-Contract <u>providers</u> not registered with CMS are not covered.
	<u>Habilitation services</u>	Therapy done as part of an approved autism plan: 10% <u>coinsurance</u> ;	Not covered	Coverage is limited to therapy that is being done as part of an approved autism plan.

\* For more information about limitations and exceptions, see the Plan or policy document at [www.carpenterfunds.com](http://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)	
		Other services: Not covered		
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is recommended. Limited to 70 days per confinement. Services from Non-Contract <u>providers</u> not registered with CMS are not covered.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Rental covered up to reasonable purchase price.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<b>Outpatient:</b> Services from Non-Contract <u>providers</u> not registered with CMS are limited to \$200/appointment. <b>Inpatient:</b> Services from Non-Contract <u>providers</u> 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 <u>copayment</u> /exam	\$10 <u>copayment</u> /exam	Vision benefits are available through a separate vision <u>plan</u> . Your <u>cost sharing</u> does not count toward the medical <u>plan's out-of-pocket limit</u> .
	Children's glasses	\$25 <u>copayment</u> , plus all amounts over \$175 for frames	\$25 <u>copayment</u> , plus all amounts over \$35 for single vision lenses and amount over \$45 for frames	
	Children's dental check-up	No charge, a <u>deductible</u> 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 <u>plan</u> . Your <u>cost sharing</u> does not count toward the medical <u>plan's out-of-pocket limit</u> .



**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  | • Infertility treatment | • Private-duty nursing |
| • <u>Habilitation services</u> (except for therapy that is being done as part of an approved autism plan) | • Long-term 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 (up to \$35/visit and 20 visits per calendar year)                                   | • Dental care (Adult) (up to \$2,500 for Contract and \$2,000 for Non-Contract per calendar year) | • Non-emergency care when traveling outside the U.S.            |
| • Bariatric surgery (with precertification)  | • Hearing aids (limited to \$800/ear in any 3-year period)  | • Routine eye care (Adult) (under separate vision <u>plan</u> ) |
| • Chiropractic care (Employee and spouse only. Up to \$25/visit up to 20 visits per calendar year) |   | • Routine foot care   |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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 <u>deductible</u>	\$128
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

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

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$128
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

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

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$128
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

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





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

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

PID:9076 CNTR:1 EU:0 Plan ID:1161 SBC ID:471218

1 of 6



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 / visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$20 / visit	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs (Tier 1)	Retail: \$10 / prescription; Mail order: \$20 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines. No Charge for Contraceptives.
	Preferred brand drugs (Tier 2)	Retail: \$30 / prescription; Mail order: \$60 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines. No Charge for Contraceptives.
	Non-preferred brand drugs (Tier 2)	Same as preferred brand drugs	Not Covered	The <a href="#">cost-sharing</a> for non-preferred brand drugs under this <a href="#">plan</a> aligns with the <a href="#">cost-sharing</a> for preferred brand drugs (Tier 2), when approved through the <a href="#">formulary</a> exception process.
	<a href="#">Specialty drugs</a> (Tier 4)	30% <a href="#">coinsurance</a> up to \$150 / prescription	Not Covered	Up to a 30-day supply retail. Subject to <a href="#">formulary</a> guidelines.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$20 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	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)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 / visit	\$100 / visit	None
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	None
	<a href="#">Urgent care</a>	\$20 / visit	\$20 / visit	<a href="#">Non-Plan providers</a> 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	\$20 / individual visit. No charge 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 <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> 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	<a href="#">Home health care</a>	No Charge	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	<a href="#">Rehabilitation services</a>	Inpatient: \$250 / admission Outpatient: \$20 / visit	Not Covered	None
	<a href="#">Habilitation services</a>	\$20 / visit	Not Covered	None
	<a href="#">Skilled nursing care</a>	\$250 / admission	Not Covered	Up to 100 days maximum / benefit period.

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)	
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	Requires prior authorization.
	<a href="#">Hospice services</a>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S	• Routine foot care	
• Dental care (Adult and child)	• Private-duty nursing	• Weight loss programs	
• Long-term care			
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
• Acupuncture (plan provider referred)	• Chiropractic care (30 visit limit / year)	• Infertility treatment	
• Bariatric surgery	• Hearing aids (\$2500 limit / ear every 36 months)	• 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](http://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 <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>
California Department of Insurance	1-800-927-HELP (4357) or <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a>
California Department of Managed Healthcare	1-888-466-2219 or <a href="http://www.healthhelp.ca.gov/">www.healthhelp.ca.gov/</a>

**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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$20
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other (blood work) <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$350</b>

## Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$20
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other (blood work) <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$800</b>

## Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$20
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other (x-ray) <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$200</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## CARPENTER FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA, INC.

[carpenterfunds.com](http://carpenterfunds.com)

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

July 2023

**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 are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible 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.

**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.)**

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 15<sup>th</sup> through December 7<sup>th</sup>); 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](http://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](http://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](http://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](http://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 2023** is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.



## **CARPENTER FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA, INC.**

[carpenterfunds.com](http://carpenterfunds.com)

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

**July 2023**

**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](http://www.carpenterfunds.com), or emailing, [benefitservices@carpenterfunds.com](mailto: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**

**Kaiser HMO:** 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.

**Indemnity Plan:** 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.

## **DIRECT ACCESS TO OBSTETRICAL / GYNECOLOGICAL PROVIDERS**

**Kaiser HMO:** 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.

**Indemnity Plan:** 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 (800) 274-7767.

## **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](http://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](http://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](http://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, 2023. Contact your State for further information on eligibility.**

<b>ALABAMA – Medicaid</b>	<b>ALASKA – Medicaid</b>	<b>ARKANSAS – Medicaid</b>
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>	Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (1-855-692-7447)
<b>CALIFORNIA – Medicaid</b>	<b>COLORADO – Health First Colorado (Colorado's Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b>	<b>FLORIDA – Medicaid</b>
Website: Health Insurance Premium Payment (HIPP) Program <a href="https://dhcs.ca.gov/hipp">https://dhcs.ca.gov/hipp</a> Phone: 1-916-445-8322 Fax: 1-916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>	Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a> HIBI Customer Service: 1-855-692-6442	Website: <a href="https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html">https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268



<b>GEORGIA – Medicaid</b> GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 1-678-564-1162, Press 1 GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a> Phone: 1-678-564-1162, Press 2	<b>INDIANA – Medicaid</b> Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> Phone: 1-800-457-4584	<b>IOWA – Medicaid and CHIP (Hawki)</b> Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Hawki Phone: 1-800-257-8563 HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a> HIPP Phone: 1-888-346-9562
<b>KANSAS – Medicaid</b> Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012	<b>KENTUCKY – Medicaid</b> Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPPROGRAM@ky.gov">KIHIPPROGRAM@ky.gov</a>  KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a> Phone: 1-877-524-4718  Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a>	<b>LOUISIANA – Medicaid</b> Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicare hotline) or 1-855-618-5488 (LaHIPP)
<b>MAINE – Medicaid</b> Enrollment Website: <a href="https://www.maine.gov/dhhs/ofi/">https://www.maine.gov/dhhs/ofi/</a> Phone: 1-800-442-6003 TTY: Maine relay 711  Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone 1-800-977-6740 TTY: Maine relay 711	<b>MASSACHUSETTS – Medicaid and CHIP</b> Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a> Phone: 1-800-862-4840 TTY: (617) 886-8102	<b>MINNESOTA – Medicaid</b> Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a>  Phone: 1-800-657-3739
<b>MISSOURI – Medicaid</b> Website: <a href="https://www.dss.mo.gov/mhd/participants/pages/hipp.htm">https://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 1-573-751-2005	<b>MONTANA – Medicaid</b> Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084 Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a>	<b>NEBRASKA – Medicaid</b> Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
<b>NEVADA – Medicaid</b> Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900	<b>NEW HAMPSHIRE – Medicaid</b> Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Phone: 1-603-271-5218 Toll-Free number for the HIPP program: 1-800-852-3345, ext. 5218	<b>NEW JERSEY – Medicaid and CHIP</b> Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 1-609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710

ERRATA: January 27, 2023

<b>NEW YORK – Medicaid</b> Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831	<b>NORTH CAROLINA – Medicaid</b> Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 1-919-855-4100	<b>NORTH DAKOTA – Medicaid</b> Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825
<b>OKLAHOMA – Medicaid and CHIP</b> Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	<b>OREGON – Medicaid</b> Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075	<b>PENNSYLVANIA – Medicaid and CHIP</b> Website: <a href="https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx">https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx</a> Phone: 1-800-692-7462  CHIP Website: <a href="https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx">Children's Health Insurance Program (CHIP) (pa.gov)</a> CHIP Phone: 1-800-986-KIDS (5437)
<b>RHODE ISLAND – Medicaid and CHIP</b> Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rlte Share Line)	<b>SOUTH CAROLINA – Medicaid</b> Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820	<b>SOUTH DAKOTA – Medicaid</b> Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059
<b>TEXAS – Medicaid</b> Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a> Phone: 1-800-440-0493	<b>UTAH – Medicaid and CHIP</b> Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669	<b>VERMONT – Medicaid</b> Website: <a href="https://www.vermont.gov/business/health/hipp/">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a> Phone: 1-800-250-8427
<b>VIRGINIA – Medicaid and CHIP</b> Website: <a href="https://www.coverva.org/en/famis-select">https://www.coverva.org/en/famis-select</a> <a href="https://www.coverva.org/en/hipp">https://www.coverva.org/en/hipp</a>  Medicaid/CHIP Phone: 1-800-432-5924	<b>WASHINGTON – Medicaid</b> Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022	<b>WEST VIRGINIA – Medicaid and CHIP</b> Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a> <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Medicaid Phone: 1-304-558-1700 CHIP Toll-free Phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>WISCONSIN – Medicaid and CHIP</b> Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002	<b>WYOMING – Medicaid</b> Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269	

To see if any other States have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
**[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)**  
1-877-267-2323, Menu Option 4, Ext. 61565

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

Plan Year – September 1, 2021 through August 31, 2022

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, 2021 through August 31, 2022. 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, 2022 were \$299,514,734.

### Basic Financial Statement:

The value of Plan assets, after subtracting liabilities of the Plan, was \$736,546,487 minus premiums and self-funded claims payable of \$71,299,311, minus claims incurred but not reported of \$23,236,000, minus bank of hours liability of \$168,325,000, equals \$473,686,176 as of August 31, 2022, compared to \$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 September 1, 2021. During the Plan year, the Plan experienced an increase in its net assets of \$60,865,426. 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 \$424,116,674; including employer contributions of \$395,146,547, participant contributions of \$31,392,471, realized gains of \$6,259,737 from the sale of assets, losses from investments of \$32,291,696, and other income of \$23,609,615.

Plan expenses were \$484,982,100. These expenses included \$14,355,714 in administrative expenses, \$2,273,045 in investment expenses, \$299,514,734 in premium costs, and \$168,838,607 in self-funded benefits paid directly to participants and beneficiaries or to service providers on their behalf.

<i>Condensed Financial Statement</i>		
<b>Beginning Balance Value of Net Plan Assets</b>	<b>As of 9/01/2020 \$482,783,275</b>	<b>As of 9/01/2021 \$534,551,602</b>
Employer Contributions	\$407,404,683	\$395,146,547
Participant Contributions	\$31,498,363	\$31,392,471
Investments – Earnings/Losses	\$40,208,384	\$-32,291,696
Sale of Assets - Earnings	\$41,189,910	\$6,259,737
Other Income	\$20,172,879	\$23,609,615
<b>Plan Income</b>	<b>\$540,474,219</b>	<b>\$424,116,674</b>
Insurance Premiums	\$293,341,241	\$299,514,734
Self-Funded Benefits	\$179,995,596	\$168,838,607
Administrative Fees	\$13,711,927	\$14,355,714
Investment Expenses	\$1,657,128	\$2,273,045
<b>Total Expenses</b>	<b>\$488,705,892</b>	<b>\$484,982,100</b>
<b>Ending Balance Value of Net Plan Assets</b>	<b>As of 08/31/2021 \$534,551,602</b>	<b>As of 08/31/2022 \$473,686,176</b>

### **Your Rights to Additional Information:**

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

### **Obtaining Copies of a Summary Annual Report:**

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

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

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

### **AVISO**

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