



# Carpenters Health & Welfare Trust Fund for California

## Comparison for Plan B & Flat Rate Benefits

<b>QUICK REFERENCE</b>	
Information Needed:	Contact the Following:
Eligibility, Benefits, COBRA, Disability, or Life and Accidental Death and Dismemberment (AD&D) Claims	Fund Office (510) 633-0333 or Toll Free (888) 547-2054
Claims: Indemnity Medical Plan Orthodontic Benefit (Indemnity & Kaiser) Indemnity Hearing Aid Benefit	Claims Office - Direct (925) 676-3828 Toll Free - In California (800) 323-6661 Toll Free - Outside California (800) 232-2527 <a href="http://www.carpenterfunds.com">www.carpenterfunds.com</a>
Contract Provider Program – In California (Indemnity Medical Plan)	Claims Office (925) 676-3828 or Toll Free (800) 323-6661 <a href="http://www.anthem.com/ca">www.anthem.com/ca</a>
Contract Provider Program – Outside California (Indemnity Medical Plan)	BlueCard (800) 810-2583 <a href="http://www.bluecares.com">www.bluecares.com</a>
Review Organization for Required Pre-Authorizations – In or Outside California (Indemnity Medical Plan)	Anthem Blue Cross (800) 274-7767
Prescription Drug Benefits (Indemnity Medical Plan)	Medco (800) 939-7093 <a href="http://www.medco.com">www.medco.com</a> Fund Office (888) 547-2054
Vision Service Plan (Indemnity Medical Plan)	(800) 877-7195 <a href="http://www.vsp.com">www.vsp.com</a>
Kaiser Permanente	(800) 464-4000 <a href="http://my.kp.org/ca/carpenterfunds/index.html">http://my.kp.org/ca/carpenterfunds/index.html</a>
Delta Dental (Delta Preferred Option)	(800) 765-6003 <a href="http://www.deltadentalca.org">www.deltadentalca.org</a>
PacifiCare Behavioral Health Member Assistance Program	(877) 225-2267 <a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a>

Please note: This summary is a brief description of Carpenters Health and Welfare Plan benefits. In all cases, the Plan Rules and Regulations, including any amendments, will be the basis for the payment of any benefits.

<b>BENEFITS</b>	<b>KAISER</b>	<b>INDEMNITY</b>
Plan Selections	A Health Maintenance Organization (HMO) that provides prepaid medical, drug, vision and hearing aid benefits to Participants enrolled in this Plan with a guaranteed payment of these benefits. Participants must live within the Service Areas.	The Indemnity Plan is a comprehensive benefit plan with an annual deductible and a limit on your annual out of pocket for covered expenses. After the out of pocket limit is reached each year, the Plan will pay 100% of covered expenses for the remainder of the calendar year.
Phantom COB (Coordination of Benefits)	Phantom COB does not apply	Phantom COB: If the participant's spouse is employed and the employer offers insurance, the spouse must elect coverage. If he or she declines coverage, the Indemnity Plan will pay up to 20% of covered medical bills. The Fund will estimate the benefits of the other group plan at 80% of expenses incurred and will coordinate its benefits with the estimated benefits.
Annual Deductible	None	Calendar Year - Per person PPO: \$100 Non-PPO: \$200 Maximum deductible - Per family PPO: \$200 Non-PPO: \$400
Annual Out of Pocket Limits	Limit on co-payments Per person - \$1,500 Per family - \$3,000	Out of Pocket Limits per Person PPO: \$10,000 Non-PPO: \$20,000
Co-Payments	Shown for each service	Once annual deductible is satisfied and until the out of pocket limit is met, the Plan pays: PPO at 80% of contract rates and Non-PPO at 60% of C & R (Customary and Reasonable) for all benefits unless otherwise indicated.
Plan Lifetime Maximum	None	\$2,000,000
Choice of Physicians	Members choose a Physician on staff at a Kaiser Permanente facility located in their service area. Routine, preventive, and specialist care are provided at Kaiser Permanente facilities or by Kaiser contract providers.	Members may use the providers of their choice; however to receive maximum benefits, members must use PPO/contract providers.
Hospital Services	No Charge	Inpatient: Subject to deductibles and out of pocket limits. Hospital and physician benefits reduced by 25% if utilization review is not obtained. Outpatient: Subject to deductibles and out of pocket limits. PPO: 80% Non-PPO: 60%

**BENEFITS****KAISER****INDEMNITY**

Hospital Emergency Room	\$50 per visit, waived if admitted to hospital.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Physician Office Visits	\$20 per visit	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Surgical Services	No Charge	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
X-rays & Lab	No Charge	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Maternity	Co-payments for physician visits, hospital and surgery apply.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Sterilization Benefits	Co-payment required	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Ambulance	No Charge	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 80% C&R

**PREVENTIVE CARE**

Adult Physical Exam (Dependent Children NOT covered for physical exam)	\$20 per visit	The following benefits are subject to plan deductibles and are paid at 80% PPO or 60% Non-PPO: Adult physical limited to \$250 each year. Out of pocket limits do not apply to charges in excess of the benefit limits. Colonoscopy, Sigmoidoscopy, Mammograms and PSA test covered at contract rates for PPO or C&R for Non-PPO, paid at 80% PPO, 60% Non-PPO. PSA covered for participants age 50 and over.
Well Baby Care	\$5 per visit up to age two, \$20 per visit age two and over	Covered up to age two only, subject to deductible and out of pocket limits, paid at 80% PPO or 60% Non-PPO.

**BENEFITS****KAISER****INDEMNITY**

Female Routine Exam	\$20 per visit	See "Adult Physical Exam" above. Exam limited to \$250 in combination with adult physical exam each year. Subject to deductibles and out of pocket limits. Additional allowance for a pap smear.
Immunization (Dependent Children Only)	No Charge	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Allergy Testing and Treatment	\$20 per visit, \$3.00 per injection	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%

**MENTAL HEALTH BENEFITS**

Inpatient, Partial and Day Treatment	No charge, up to 45 days per calendar year. Requires prior authorization. Days are determined based on the following ratios: Inpatient treatment - 1 day; Residential treatment - 70% of 1 day; Day treatment - 60% of 1 day	Benefit provided by PacifiCare. In-Network - 90%, no deductible. Out-of-Network - 40% of C&R, no deductible. 20 days maximum per calendar year (combined maximum for in-network and out-of-network). All services must be pre-authorized or no benefits will be payable.
Outpatient	\$20 per visit for individual, \$10 per visit for group. Limited to 20 visits per year. Requires prior authorization. Days are determined based on the following ratios: Inpatient treatment - 1 day; Residential treatment - 70% of 1 day; Day treatment - 60% of 1 day	Benefit provided by PacifiCare. In-Network - \$20 copay per visit Out-of-Network - 50% of C&R, no deductible. 20 visits maximum per calendar year (combined in-network and out-of-network maximum)
Serious Mental Illness	For Serious Mental Illness, there is no limit on the number of inpatient days or outpatient visits per year. Serious Mental Illness diagnoses include: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Pervasive Developmental Disorders (Autism), Anorexia, Bulimia Nervosa, Severe Emotional Disturbances of Children (SED)	In-Network Inpatient - 90%, no deductible, unlimited days. In-Network Outpatient - \$20 copay per visit, unlimited visits. All treatment must be pre-authorized or no benefits are payable. <b>Out-of-Network - Not a covered benefit</b>

**ALCOHOL & CHEMICAL DEPENDENCY TREATMENT  
PROVIDED BY PACIFICARE BEHAVIORAL HEALTH**

All levels of Chemical Dependency Care (including detoxification)	In-Network Only - \$0 copay, covered at 100%. Requires prior authorization.	In-Network - 100%, no deductible Out-of-Network - 50%, no deductible. All services must be pre-authorized or no benefits are payable.
Annual Maximum	\$25,000	\$25,000
Lifetime Maximum	\$35,000	\$35,000

**MEMBER ASSISTANCE PROGRAM (MAP) -  
PROVIDED BY PACIFICARE BEHAVIORAL HEALTH**

Counseling Sessions with a PBH network counselor	3 visits per incident at \$0 copay (In-Network) counseling and community resources referrals (Deductible does not apply)	3 visits per incident at \$0 copay (In-Network - Pre-authorization required), community resources referrals (Deductible does not apply)
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**OTHER MEDICAL SERVICES**

Home Health Care	No Charge	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Skilled Nursing Facilities	No Charge; Limited to 100 days per benefit period.	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60% Limited to 70 days per period of confinement. Utilization review is recommended.
Short Term Therapy (Physical, Speech, Occupational)	\$20 per visit	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Chiropractic	Self-referral; must use network providers. \$10 per visit, limited to 30 visits per year.	Benefit for Participant and Spouse only. Maximum payment of \$25 per visit and 20 visits per calendar year. Subject to deductibles. Out of pocket limits do not apply to charges over plan maximums.
Acupuncture	Available with referral	Maximum payment of \$35 per visit and 20 visits per calendar year. Subject to deductibles. Out of pocket limits do not apply to charges over plan maximums.

**BENEFITS****KAISER****INDEMNITY**

Podiatry	\$20 per visit	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%
Durable Medical Equipment	No Charge	Subject to deductibles and annual out of pocket limits. PPO: paid at 80% Non-PPO: paid at 60%

**VISION BENEFITS**

Vision Exam	\$20 per visit, must use Kaiser Optical	Vision exam through Vision Service Signature Choice Plan every 12 months after \$10 co-payment.
Glasses and Contact Lenses	Maximum allowance of \$125 for glasses or contact lenses. Benefit renews every 24 months.	Covered through Vision Service Signature Choice Plan after \$25 co-payment for materials. Provides one pair of lenses every 12 months and frames every 24 months. Necessary contact lenses paid in full.

**PRESCRIPTION DRUGS**

Retail Pharmacy	\$10 for generic drug \$30 for formulary brand drug Prescriptions from Non-Kaiser providers (other than Dentists) are NOT covered. Maximum 100-day supply.	\$10 for formulary generic drug Retail contract pharmacies only, unless there are none within 10 miles. \$10, PLUS cost difference between generic and brand for multi-source brand. \$40 for single source formulary brand. \$60 for non-formulary - Certain non-formulary drugs are not covered without prior authorization. 30 day supply.
Mail Order	\$10 for generic drug \$30 for formulary brand drug Maximum 100-day supply. Mail orders on reorder prescriptions only. Call your local Kaiser Pharmacy for further details or see Kaiser's website at <a href="http://my.kp.org/ca/carpenterfunds/index.html">http://my.kp.org/ca/carpenterfunds/index.html</a> Prescriptions from Non-Kaiser providers (other than Dentists) are NOT covered.	\$20 for formulary generic drug. \$20 PLUS cost difference between generic and brand for multi-source brand. \$80 for single source formulary brand. \$100 for non-formulary. Certain non-formulary drugs are not covered without prior authorization. 90-day supply.
Hearing Exam & Hearing Aids	\$20 per visit; \$2,500 maximum for each hearing aid. Hearing aids are provided every 36 months.	Maximum benefit limits: 100%, up to \$800 maximum for each ear, including the exam only if the hearing aid(s) are obtained. Hearing aids provided every 3 years. (Not subject to deductibles or out of pocket limits.)

**BENEFITS****KAISER****INDEMNITY**

Coverage Areas	See attached page for a zip code listing of covered areas.	PPO/Contract facilities available throughout California and the U.S. Call 1(800) 323-6661 to verify contract providers in California, or 1 (800) 810-2583 for contract providers outside California
Where to go for more information	1(800) 464-4000 <a href="http://my.kp.org/ca/carpenterfunds/index.html">http://my.kp.org/ca/carpenterfunds/index.html</a>	Trust Fund Office 1(888)547-2054 or 1(510) 633- 0333 <a href="http://www.carpenterfunds.com">http://www.carpenterfunds.com</a>

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**DENTAL BENEFITS  
FOR KAISER & INDEMNITY PARTICIPANTS**

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In-Network: Delta Dental Preferred Option (DPO)	Maximum - \$2,500 per patient per calendar year Diagnostic & Preventive - 100% Contract Rate Basic Services - 80% Contract Rate Crowns & Cast Restorations - 80% Contract Rate Prosthodontics - 80% Contract Rate
Out of Network: Delta Premiere	Maximum - \$2,000 per patient per calendar year Diagnostic & Preventive - 100% Contract Rate Basic Services - 50% Contract Rate Crowns & Cast Restorations - 50% Contract Rate Prosthodontics - 50% Contract Rate
Maximum	The maximum benefit is \$2,500 per year, reduced to \$2,000 for services of Non-PPO dentists. The above maximums are not separate maximums.

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**ORTHODONTIC BENEFITS**

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Orthodontic Benefits for Dependent Children	Benefits covered by Indemnity Medical Plan, not Delta Dental. Plan pays 50% of covered charges to a maximum of \$1,500 per dependent child to the age of 19.
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**DEFINITIONS**

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Generic	A drug identified by its chemical name - an equivalent version of a brand name drug whose exclusive patent has expired.
Multi-Source Brand	A brand name drug that has a generic equivalent.
Single Source Formulary Brand	A brand name drug that has no generic equivalent and is placed on a list of preferred formulary drugs by the pharmacy benefit manager.
Non-Formulary Drug	A drug that is NOT on a list of preferred formulary drugs.
C&R	Customary and reasonable
Phantom COB (Coordination of Benefits)	If the participant's spouse is employed and the employer offers insurance, the spouse must elect coverage.

**Northern California Service Area for Kaiser Permanente**

The Service Area is only that portion of Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba counties within the following ZIP codes:

93230	93701-12	94059-67	94256-59	94649	95008-09	95215	95363	95465	95722
93232	93714-18	94070-71	94261-63	94659-62	95011	95219-20	95366-68	95471-73	95736
93238	93720-22	94074	94267-69	94666	95013-15	95227	95376-78	95476	95741-43
93242	93724-29	94080	94271	94701-10	95020-21	95230-31	95380-82	95486-87	95746-47
93261	93740-41	94083	94273-74	94712	95026	95234	95385-87	95492	95757-59
93601-02	93744-45	94085-90	94277-80	94720	95030-33	95236-37	95391	95602-05	95762-63
93604	93747	94096	94282-91	94801-08	95035-38	95240-42	95397	95607-21	95765
93606-07	93750	94098-99	94293-99	94820	95042	95253	95401-09	95623-26	95776
93609	93755	94101-12	94301-10	94850	95044	95258	95416	95628	95798-99
93611-14	93760-62	94114-47	94401-09	94875	95046	95267	95419	95630	95812-38
93616	93764-65	94150-72	94497	94901	95050-56	95269	95421	95632-35	95840-43
93618-19	93771-80	94175	94501-03	94903-04	95070-71	95296-97	95425	95638-41	95851-53
93623-27	93784	94177	94506-31	94912-15	95076	95304	95430-31	95645	95857
93630-31	93786	94188	94533-53	94920	95101-03	95307	95433	95648	95860
93637-39	93790-94	94199	94555-66	94922-31	95106	95313	95436	95650-52	95864-67
93643-46	93844	94203-09	94567*	94933	95108-42	95316	95439	95655	95887
93648-54	93888	94211	94568-83	94937-42	95148	95319-20	95441-42	95658-64	95894
93656-57	94002-03	94229-30	94585-92	94945-57	95150-61	95323	95444	95667-74	95899
93660	94005	94232	94595-99	94960	95164	95326	95446	95676-78	95903
93662	94010-12	94234-37	94601-15	94963-66	95170-73	95328-30	95448	95680-83	95961
93666-69	94013-31	94239-40	94617-25	94970-79	95190-94	95336-37	95450	95686-88	
93673	94035	94243-50	94627	94998-99	95196	95350-58	95452	95690-98	
93675	94037-45	94252-54	94643	95002	95201-13	95360-61	95462	95703	

\*Knoxville is not in the Service Area.

**Southern California Service Area for Kaiser Permanente**

The Service Area is that portion of Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura counties within the following ZIP codes:



90001-84	90637-40	91030-31	91392-96	91780	92071-72	92282*	92543-46	92831-38	93276
90086-89	90650-52	91040-43	91399	91784-86	92074-75	92284-86*	92548	92840-46	93280
90091	90659-62	91046	91401-13	91788-93	92078-79	92292*	92551-57	92850	93285
90093-97	90665	91066	91416	91795	92081-85	92305	92562-64	92856-57	93287
90099	90670-71	91077	91423	91797-99	92090-93	92307-08	92567	92859-71	93301-09
90101-03	90680	91101-10	91426	91801-04	92096	92313-18	92570-72	92877-83	93311-14
<b>90174</b>	<b>90701-03</b>	<b>91114-18</b>	<b>91436</b>	<b>91841</b>	<b>92101-24</b>	<b>92320-22</b>	<b>92581-87</b>	<b>92885-87</b>	<b>93380-90</b>
90185	90706-07	91121	91470	91896	92126-40	92324-26	92595-96	92899	93501-02
90189	90710-17	91123-26	91482	91899	92142-43	92329	92599	93001-07*	93504-05
90201-02	90720-21	91129	91495-97	91901-03	92145	92333-37	92602-07	93009*	93510
90209-13	90723	91131	91499	91908-17	92147	92339-41	92609-10	93010-12	93518-19
90220-24	90731-34	91175	91501-08	91921	92149-50	92344-46	92612	93015-16	93531-32
90230-33	90740	91182	91510	91931-33	92152-55	92350	92614-20	93020-21	93534-36
90239-42	90742-49	91184-89	91521-23	91935	92158-79	92352	92623-30	93022*	93539
90245	90755	91191	91526	91941-47	92182	92354	92637	93030-36*	93543-44
90247-51	90801-10	91201-10	91601-12	91950-51	92184	92357-59	92646-63	93040	93550-53
90254-55	90813-15	91214	91614-18	91962-63	92186-87	92369	92672-79	93041-44*	93560-61
90260-67	90822	91221-22	91701-02	91976-80	92190-99	92371-78	92683-85	93060-61*	93563
90270	90831-35	91224-26	91706	91987	92201-03*	92382	92688	93062-66	93581
90272	90840	91301-13	91708-11	91990	92210-11*	92385-86	92690-94	93093-94	93584
90274-75	90842	91316	91714-16	92007-11	92220	92391-95	92697-98	93099	93586
90277-78	90844-48	91319-22	91722-24	92013-14	92223	92397	92701-12	93203	93590-91
90280	90853	91324-31	91729-35	92018-27	92230*	92399	92725	93205-06	93599
90290-96	90888	91333-35	91737	92029-30	92234-36*	92401-08	92728	93215-16	
90301-13	90899	91337	91739-41	92033	92240-41*	92410-15	92735	93220	
90397-98	91001	91340-46	91743-50	92037-40	92247-48*	92418	92780-82	93222	
90401-11	91003	91350-65	91752	92046	92252-56*	92423-24	92799	93224-26	
90501-10	91006-07	91367	91754-56	92049	92258*	92427	92801-09	93240-41	
90601-10	91009-12	91371-72	91758-59	92051-52	92260-64*	92501-09	92811-12	93243	
90612	91016-17	91376-77	91761-73	92054-58	92268*	92513-19	92814-17	93250-52	
90620-24	91020-21	91380-88	91775-76	92064-65	92270*	92521-22	92821-23	93263	
90630-33	91023-25	91390	91778	92067-69	92274-78*	92530-32	92825	93268	

\*Subscribers residing in Coachella Valley (greater Palm Springs area) and western Ventura County ZIP codes are required to select a primary care Plan Physician (Affiliated Physician). Members will be contacted after enrollment regarding Plan Physician (Affiliated Physician) selection.