Carpenters Southwest Administrative Corporation
533 South Fremont Avenue • Los Angeles, California 90071-1706 • Tel: 213-386-8590 • Toll Free: 800-293-1370
www.carpenterssw.org

To: All Active and COBRA Participants of the Southwest Carpenters Health and Welfare Trust and their Covered Dependents

From: The Board of Trustees

Important Participant Benefit Program Notices

Updated 9-30-17

This document contains important participant benefit program notices of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time to time and some of the federal notices are updated each year. Be sure you are reviewing an updated version of this important notices document.

Aviso a los participantes que hablan Español: Si tiene alguna pregunta tocante este aviso o requiere alguna otra información tocante a su cobertura de salud, por favor de comunicarse con la Oficina Administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.

MEMBERXG IS NOW AVAILABLE TO PARTICIPANTS AND DEPENDENTS!

Please see the MemberXG flyer in this mailing for information on how you and your covered dependents can access the MemberXG portal to get updated information regarding your benefits.

DENTAL PLAN ENHANCEMENTS

Effective January 1, 2018, the Trust approved dental benefit enhancements for all of the Dental HMO and Dental PPO Plans. For the Dental HMO Plans, the orthodontic copays will decrease to $1,000 for Children to age 19 and $1,200 for Adults and Children age 19-26 (except $1,000 Adult copay for UHC DHMO-California).

For the Delta Dental DPPO Plan, the Calendar Year Maximum and the Children Orthodontic Lifetime Maximum will be increased from $1,500 to $2,000. In addition, the Delta Dental DPPO Plan will include the Diagnostic and Preventive Waiver, which means charges from diagnostic and preventive services will not count towards the Calendar Year Maximum.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) CARRIER

Effective January 1, 2018, the Trust approved changing from Voya to MetLife to provide Life, AD&D, and Dependent Life Insurance. This change does not require any action from you regarding your beneficiary card on file with the Trust. However, this is a good time to review and make sure your beneficiary information is up to date.

ANNUAL NOTICE OF 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, copayment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by the Trust. For more information on WHCRA benefits, contact the Administrative Office at 213-386-8590 or toll-free at 1-800-293-1370.

REMINDER ON LOCATING A HIPAA PRIVACY NOTICE

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.

The HIPAA Privacy Notice related to the self-funded Medical PPO plan explains how the group health plan uses and discloses your personal health information. You are provided a copy of this HIPAA Privacy Notice when you enroll in the Medical PPO Plan. You can get another copy of this Notice from the Administrative Office at 213-386-8590 or toll-free at 1-800-293-1370 or on the Trust's website at www.carpenterssw.org.

If you are covered under an insured program such as Kaiser or UnitedHealthcare (UHC), you should have received a HIPAA Privacy Notice outlining their privacy practices directly from the insurance company. You can get another copy of the insurance company's HIPAA Privacy Notice from the insurer directly (at the telephone number listed in your Summary Plan Description, or on the Trust's website at www.carpenterssw.org).

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

Our Plan is 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. We 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, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. 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 that are enrolled in the Trust's health plan, please contact the Administrative Office at 213-386-8590 or toll-free at 1-800-293-1370.

IRS FORMS TO BE PROVIDED TO YOU

As required by the Affordable Care Act, early each year, you will receive an IRS Form 1095-B in the mail if you or your dependents have been covered under one of the Trust's medical plans during the previous calendar year. For each calendar month that you were enrolled in a medical plan, the 1095-B form documents that you (and any enrolled family members) met the federal requirement to have "minimum essential coverage," meaning group medical plan coverage. Having minimum essential coverage means you and your family members may not have to pay the Individual Mandate penalty when you file your personal income taxes. Visit the Health Insurance Marketplace at https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/ for detailed information on this penalty.

If you receive a Form 1095-B, you will want to keep this form in a safe place because you may need to produce it if requested by the IRS. If you have not been covered by a medical plan during the prior calendar year, you will not receive a Form 1095-B.

If you have been covered by various medical plans during a calendar year, you may receive more than one Form 1095-B. Questions about the 1095-B forms can be directed to the Administrative Office at 213-386-8590 or toll-free at 1-800-293-1370.

AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you provide important protection for you and your family in the case of illness or injury. In accordance with law, our plan provides you with a Summary of Benefits and Coverage or SBC for each medical plan option as a way to help you understand and compare medical plan benefits. The SBC summarizes and compares important information including, what is covered, what you need to pay for various benefits, what is not covered and where to get

answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC and are also included with the enclosed materials.

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, go to www.carpenterssw.org or, for a paper copy, contact the Administrative Office at 213-386-8590 or toll-free at 1-800-293-1370.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans 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 or Health Care Practitioner, 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 or other Health Care Practitioner 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 precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for cesarean section, contact the medical plan in which you are enrolled (contact phone number listed on your ID card). If you have questions about this Notice, contact the Administrative Office at 213-386-8590 or toll-free at 1-800-293-1370.

KEEP THE ADMINISTRATIVE OFFICE NOTIFIED OF CHANGES

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your Dependents must promptly notify the Administrative Office in any of the following events: change of name, change of address, marriage, divorce or legal separation, death of a covered family member, birth, change in status of a Dependent Child, Medicare enrollment or disenrollment, meeting the termination provisions of the Plan or the existence of other coverage. Legal documentation will be required for certain changes.

Notification is preferred within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give the Administrative Office timely notice of the above noted events may:

a. prevent you and/or your Dependents from obtaining the right to COBRA Continuation Coverage,
b. terminate coverage of a Dependent Child when coverage might have otherwise continued due to a disability,
c. cause claims to be denied payment until eligibility issues have been resolved,
d. result in your liability to reimburse the Plan if benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental and/or vision benefits.

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums/contributions are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud.

If you have questions about eligibility contact the Administrative Office at 213-386-8590 or toll-free at 1-800-293-1370.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT FOR HMO PARTICIPANTS

Designation of a Primary Care Provider (PCP):

The HMO medical plans generally allow 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 your HMO at the phone number listed on your medical plan ID card or visit www.carpenterssw.org.

Direct Access to OB/GYN Providers:

You do not need prior authorization (pre-approval) from any of the Trust's HMO medical plans 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 your HMO at the phone number listed on your medical plan ID card or visit www.carpenterssw.org.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT FOR PLAN PARTICIPANTS NOT ENROLLED IN AN HMO MEDICAL PLAN

The non-HMO medical plans offered by the Trust do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider.

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a 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 (OB/GYN), contact your medical plan (phone number listed on your medical plan ID card) or visit www.carpenterssw.org.

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

After an enrollment period is completed, you **will not** be allowed to change your benefit elections or add/delete dependents until next years' open enrollment period, unless you have a Special Enrollment Event, as outlined below.

Special Enrollment Event: If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependent(s) if you **request enrollment within 31 days** from the qualifying event.

You and your eligible dependents may also enroll in a Medical 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.

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).

To request Special Enrollment or obtain more information, contact the Administrative Office at 213-386-8590 or toll-free at 1-800-293-1370.

Medicare Part D Notice for Active Carpenters (not enrolled in the Basic Medical Plan)

Important Notice from Southwest Carpenters Health and Welfare Trust about Prescription Drug Coverage for People with Medicare

This Notice is for people with 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 Southwest Carpenters Health and Welfare Trust 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.

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare, we have decided to provide this Notice to all plan participants.

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 has determined that the prescription drug coverage is "CREDITABLE" under the following medical plan options:
Kaiser HMO Plan, UHC HMO, EPO and PPO Plans, Select Health HMO Plan, HPN HMO, Anthem Blue Cross HMO Plan, and the self-funded PPO Plan.

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the medical plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under these medical plans 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 fee 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 3 times:

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

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

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this Notice at least every 12 months and at other times in the future such as 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 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any one of the following options:

Your Choices:	What you can do:	What this option means to you:
Option 1	You keep your current medical and prescription drug coverage and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through your medical plan. • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th through December 7th 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 fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	You can keep your current medical and prescription drug coverage **and also enroll in a Medicare prescription drug plan.** If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.	Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug 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 this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows: • for Medicare eligible Active Employees and their Medicare eligible Dependents, the group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under your medical plan. 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 cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

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

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

For more information about Medicare prescription drug coverage:

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

Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

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

Aviso a los participantes que hablan Español: Si tiene alguna pregunta tocante este aviso o requiere alguna otra información tocante a su cobertura de salud, por favor de comunicarse con la Oficina Administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.

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

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

Carpenters Southwest Administrative Office

533 S. Fremont Ave. Los Angeles, CA 90071-1706

Tel: (213) 386-8590 Toll Free: (800) 293-1370

As in all cases, the Board of Trustees of the Southwest Carpenters Health and Welfare Trust and, when applicable, the insurance companies of the insured medical plan options offered by the Trust reserve the right to modify benefits at any time, in accordance with applicable law.

This document (dated September 30, 2017) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

Medicare Part D Notice for Active Carpenters subject to the Drywall Agreements in Arizona, Colorado, New Mexico, & Utah

Important Notice from Southwest Carpenters Health and Welfare Trust about Prescription Drug Coverage for People with Medicare

This Notice is for people with 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 Southwest Carpenters Health and Welfare Trust 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.

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare, we have decided to provide this Notice to all plan participants.

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 has determined that the prescription drug coverage is "CREDITABLE" under the following medical plan options:
Kaiser HMO Plan, UHC HMO, EPO and PPO Plans, Select Health HMO Plan,
HPN HMO, Anthem Blue Cross HMO Plan and the self-funded PPO Plan and Bronze Plan.

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage (they are creditable), **you can elect or keep prescription drug coverage under these medical plans 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 fee penalty).

IMPORTANT NOTE: IF YOU ARE THINKING OF ENROLLING IN THE BASIC MEDICAL PLAN

The Trust has determined that the prescription drug coverage is NOT CREDITABLE under the Basic Medical Plan. "Not Creditable" means that the value of this prescription drug benefit is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay.

This means that the Basic Medical Plan is NOT as valuable as the standard Medicare prescription drug coverage. This is important because for most Medicare-eligible people who enroll in the Basic Medical Plan, enrolling in Medicare prescription drug coverage means you will get MORE assistance with drug costs than if you had prescription drug coverage exclusively through the Basic Medical Plan. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll. Read this notice carefully—it explains your options.

** If you enroll in the Basic Medical Plan and are eligible for Medicare, you should consider enrolling in Medicare prescription drug coverage.

Because the prescription drug coverage with the Basic Medical Plan is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay, you should consider enrolling in a Medicare prescription drug plan.

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 3 times:

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

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

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this Notice at least every 12 months and at other times in the future such as 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 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

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

Your Choices:	What you can do:	What this option means to you:
Option 1	If you are enrolled in a medical plan with creditable drug coverage (as explained on the first page of this notice) you keep your current medical and prescription drug coverage and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through your medical plan. • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th through December 7th 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 fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	If you are enrolled in a medical plan with creditable drug coverage (as explained on the first page of this notice) you can keep your current medical and prescription drug coverage **and also enroll in a Medicare prescription drug plan.** If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.	Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug 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 this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows: • for Medicare eligible Active Employees and their Medicare eligible Dependents, the group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under your medical plan. 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 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.

Your Choices:	What you can do:	What this option means to you:
Option 3	IMPORTANT: You can enroll in the **Basic Medical Plan**, a non-creditable prescription drug plan; **however, to avoid Medicare's late enrollment fee you should consider enrolling in Medicare prescription drug coverage.** **If you enroll in a Medicare prescription drug plan** you can keep your current medical and prescription drug coverage with the Basic Medical Plan. If you enroll in Medicare prescription drug coverage you will need to pay the Medicare Part D premium out of your own pocket.	IMPORTANT: Because the coverage under the Basic Medical Plan is NOT creditable, if you do not enroll in a Medicare prescription drug plan during Medicare's annual enrollment time, and at a later date you decide to enroll in a Medicare prescription drug plan, you may have to pay Medicare's late enrollment fee in the form of a higher monthly premium for Medicare's drug coverage at that later date when you do enroll for Medicare drug coverage. 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. If you have dual prescription drug coverage under the Basic Medical Plan and Medicare it means that the Basic Medical Plan will coordinate its drug payments with Medicare (when possible), as follows: • for Medicare eligible Active Employees and their Medicare eligible Dependents, 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 Basic Medical Plan. That is because prescription drug coverage is part of the entire Basic Medical Plan.

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

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

For more information about Medicare prescription drug coverage:

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

Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

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

Aviso a los participantes que hablan Español: Si tiene alguna pregunta tocante este aviso o requiere alguna otra información tocante a su cobertura de salud, por favor de comunicarse con la Oficina Administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.

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

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

Carpenters Southwest Administrative Office

533 S. Fremont Ave. Los Angeles, CA 90071-1706

Tel: (213) 386-8590 Toll Free: (800) 293-1370

As in all cases, the Board of Trustees of the Southwest Carpenters Health and Welfare Trust and, when applicable, the insurance companies of the insured medical plan options offered by the Trust reserve the right to modify benefits at any time, in accordance with applicable law.

This document (dated September 30, 2017) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid	INDIANA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
ALASKA – Medicaid	**IOWA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
ARKANSAS – Medicaid	**KANSAS – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**KENTUCKY – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
FLORIDA – Medicaid	**LOUISIANA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
GEORGIA – Medicaid	**MAINE – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP	PENNSYLVANIA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
MINNESOTA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
MISSOURI – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
MONTANA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEBRASKA – Medicaid	**TEXAS – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEVADA – Medicaid	**UTAH – Medicaid and CHIP**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW HAMPSHIRE – Medicaid	**VERMONT – Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NEW JERSEY – Medicaid and CHIP	**VIRGINIA – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
NEW YORK – Medicaid	**WASHINGTON – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
NORTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
NORTH DAKOTA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
OKLAHOMA – Medicaid and CHIP	**WYOMING – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
OREGON – Medicaid	
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019) 5505832v1/00539.058