Active

2026 Health Plan Benefits "At a Glance"

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Note: This document constitutes only a brief summary of the benefits available. Refer to your Summary Plan Description Book (SPD) or HMO Evidence of Coverage document available on the CSAC website at csacbenefits.org.

Medical PPO Plan Notes: Only "allowed charges" are used in determining benefits under the Medical PPO Plan. "Allowed Charge" means:

- For a PPO provider, the negotiated fee/rate in the agreement between the participating network, the provider contract rates, and Plan benefits; or
- For a Non-PPO provider (out-of-network), Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary covered services or supplies performed by Non-Network providers. Allowed amounts are based on a few factors including geographic location of provider and type of service.

The Plan will pay 100% of Allowed Charges once the amount that any individual or family pays for covered services reaches the Out-of-Pocket Maximum. The plan participant is responsible for paying their cost share, which is generally a copayment. Refer to the Summary Plan Description book for more information.

Out-of-network emergency room visits are paid at the in-network benefit level if treatment is due to a medical condition (including a mental health or substance use disorder) manifesting itself 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 various types of serious harm.

THIS IS ONLY A SUMMARY: The benefits outlined in this document are only a partial summary of benefits. Please refer to the applicable Evidence of Coverage (EOC) document or Summary Plan Description (SPD) book for prior-authorization requirements and specific restrictions, exclusions, and limitations as well as a more extensive list of services. The copayments are applicable for covered services received as described in the EOC, however, the Trust's eligibility rules, as detailed in the Summary Plan Description book issued by the Trust, apply to all active eligible participants, even those enrolled in an HMO Plan. All charges associated with non-covered services or denied claims will be the member's responsibility.

We encourage you to visit us online at csacbenefits.org. Our website provides useful information on benefits, eligibility rules, links to provider networks, forms for changes in family status and much, much more.

WESTERN STATES CARPENTERS HEALTH AND WELFARE PLAN
COMPARISON OF MEDICAL BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2026

Visit us at csacbenefits.org

MEDICAL BENEFITS	WESTERN STATES CARPENTERS			
	PPO COPAY PLAN		BRONZE PLAN	
REGIONS AVAILABLE	*ALL STATES*		*AZ, NM, CO, UT, NV, CA, WA, OR, ID, MT*	
	In-Network – Your Cost	Out-of-Network – Plan Pays	In-Network – Your Cost	Out-of-Network – Plan Pays
Calendar Year Deductible – the deductible applies to all medical benefits unless otherwise stated (Self-Only / Combined Family Maximum)	None	$500 / $1,500	$3,000 / $6,000	$10,000 / $20,000
Calendar Year Out-of-Pocket Maximum (includes deductibles and most copays & coinsurance) (Self-Only / Combined Family Maximum)	$2,500 / $5,000	None except for emergency	$5,600 / $11,200	None except for emergency
Hospital				
Inpatient	$500 per admission	50% of allowed amount	20%	50% of allowed amount
Outpatient surgery	$250 per surgery	50% of allowed amount ($5,000 max allowable per session)	20%	50% of allowed amount ($5,000 max allowable per session)
Emergency room (copay waived if admitted)	$250 per visit	$250 per visit, deductible does not apply (50% if not true emergency)	$250 per visit then 20%	$250 per visit then 20% (50% if not true emergency)
Urgent Care	$50 per visit	50% of allowed amount	20%	20% of allowed amount
Online Virtual Visits with licensed medical professional using Teladoc	$5 per visit	$5 per visit	$5 per visit	$5 per visit
Ground Ambulance Services-emergency transport	$100 per trip	$100 per trip, deductible does not apply	$50 per trip, deductible does not apply	$50 per trip, deductible does not apply
Extended Care Facility	$500 per admission	$500 per admission	None for first 30 days, 20% thereafter for room and board and 20% for other services, 180-day limit per disability	
Preventive Services – all preventive services and tests with an A or B rating from the U.S. Preventive Services Task Force are covered (additional tests may be covered as required by federal law)				
Preventive Care Office Visit	None	50% of allowed amount	None, deductible does not apply	50% of allowed amount
Physical Exam, Screenings, Laboratory and Other Tests & Immunizations	None	50% of allowed amount	None, deductible does not apply	50% of allowed amount
Physician				
Surgery – Inpatient	None for non-specialist, $30 for specialist	50% of allowed amount	20%	50% of allowed amount
Surgery – Outpatient	None for non-specialist, $30 for specialist	50% of allowed amount ($3,500 max allowable per session)	20%	50 of allowed amount % ($3,500 max allowable per session)

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MEDICAL BENEFITS	WESTERN STATES CARPENTERS			
	PPO COPAY PLAN		BRONZE PLAN	
REGIONS AVAILABLE	*ALL STATES*		*AZ, NM, CO, UT, NV, CA, WA, OR, ID, MT*	
	In-Network- Your Cost	Out-of-Network – Plan Pays	In-Network – Your Cost	Out-of-Network – Plan Pays
Hospital Visits	None for non-specialist, $30 for specialist	50% of allowed amount	20%	50% of allowed amount
Office Visits	$15 for non-specialist, $30 for specialist	50% of allowed amount	20%	50% of allowed amount
Second Surgical Opinion from a Specialist	$30 per visit	50% of allowed amount	None up to $150, deductible does not apply	50% of allowed amount
Maternity	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit at 100% in-network and 50% out-of-network); No coverage for Dependent child who becomes pregnant.		Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit at 100% in-network and 50% out-of-network); No coverage for Dependent child who becomes pregnant.	
Diagnostic X-ray, Lab (Outpatient), MRI, CT, and PET scans	$30 per visit	50% of allowed amount	20%	50% of allowed amount
Durable Medical Equipment and Corrective Appliances	$30 per item	50% of allowed amount	20%	50% of allowed amount
Hearing Aids – External	$30; subject to a $1,000 max benefit per ear every 24 months		After deductible met, Plan pays 50% of the allowed amount	
Home Health Care/Nursing Care (at home)	$30 per visit	50% of allowed amount	20%	50% of allowed amount
Chiropractor/Spinal Manipulation	$15 per visit	50% of allowed amount	All charges in excess of $10 benefit per visit, limited to 24 visits per year	
	In- & Out-of-Network limited to 24 visits per year			
Physical Therapy (short-term outpatient)	$15 per visit	50% of allowed amount	20%	50% of allowed amount
	In- & Out-of-Network limited to 20 visits per year		In- & Out-of-Network limited to 20 visits per year	
Speech Therapy (short-term outpatient restorative cases only-refer to Exclusions and Limitations in the SPD for details)	$15 per visit	50% of allowed amount	20%	50% of allowed amount
	In- & Out-of-Network limited to 130 visits per lifetime		In- & Out-of-Network limited to 130 visits per lifetime	
Acupuncture	$15 per visit	50% of allowed amount	20%	50% of allowed amount
	In- & Out-of-Network limited to 20 sessions per calendar year		In- & Out-of-Network limited to 20 sessions per calendar year	
Alcoholism & Drug Addiction				
Inpatient	$500 per visit	50% of allowed amount	20%	50% of allowed amount
Outpatient	$15 per visit	50% of allowed amount	20%	50% of allowed amount
Mental Health				
Inpatient Hospital	$500 per visit	50% of allowed amount	20%	50% of allowed amount
Outpatient	$15 per visit	50% of allowed amount	20%	50% of allowed amount
Other Covered Services and Supplies	Varying cost share may apply	50% of allowed amount	20%	50% of allowed amount

MEDICAL BENEFITS	KAISER HEALTH PLAN			
REGIONS AVAILABLE	***CA***	***CO***	***NW***	***WA***
	Your Cost	*Your Cost*	*Your Cost*	*Your Cost*
Calendar Year Deductible – the deductible applies to all medical benefits unless otherwise stated (Self-Only / Family Max)	$250 / $500	$250 / $500	$250 / $500	$250 / $500
Calendar Year Out-of-Pocket Maximum (includes deductibles and most copays & coinsurance) (Self-Only / Family)	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000
Hospital				
Inpatient	20%	20%	20%	20%
Outpatient surgery	20%	$500 in a Plan Ambulatory Surgery Center (ASC)	20%	20%
Emergency room (copay waived if admitted)	20%	20%	20%	20%
Urgent Care	$20 per visit, deductible does not apply	$20 per visit	$20 per visit, deductible does not apply	$20 per visit, deductible does not apply
Ambulance Services	$150 per trip	$150 per trip, deductible does not apply	$150 per trip, deductible does not apply	$150 per trip
Extended Care Facility	20%; limited to 100 days per benefit period	20%; limited to 100 days per benefit period	20%; limited to 100 days per benefit period	20%; limited to 100 days per benefit period
Preventive Services – all preventive services and tests with an A or B rating from the U.S. Preventive Services Task Force are covered (additional tests may be covered as required by federal law)				
Preventive Care Office Visit	None for primary care physician, specialist and well-baby/prenatal care, deductible does not apply	None for primary care physician, specialist and well-baby/prenatal care, deductible does not apply	None for primary care physician, specialist and well-baby/prenatal care, deductible does not apply	None for primary care physician, specialist and well-baby/prenatal care, deductible does not apply
Physical Exam, Screenings, Laboratory and Other Tests & Immunizations	None, deductible does not apply	None, deductible does not apply	None, deductible does not apply	None, deductible does not apply
Physician				
Surgery – Inpatient	20%	20%	20%	20%
Surgery – Outpatient	20%	$500 in a Plan Ambulatory Surgery Center (ASC)	20%	20%
Hospital Visits	20%	20%	20%	20%
Office Visits	$20 for non-specialist, $30 for specialist, deductible does not apply	$20 for non-specialist, $30 for specialist, deductible does not apply	$20 for non-specialist, $30 for specialist, deductible does not apply	$20 for non-specialist, $30 for specialist, deductible does not apply
Second Surgical Opinion from a Specialist	$30 per visit (within Kaiser), deductible does not apply	$30 per visit (within Kaiser), deductible does not apply	$30 per visit (within Kaiser), deductible does not apply	$30 per visit (within Kaiser), deductible does not apply

MEDICAL BENEFITS	KAISER HEALTH PLAN			
REGIONS AVAILABLE	***CA***	***CO***	***NW***	***WA***
	Your Cost	*Your Cost*	*Your Cost*	*Your Cost*
Maternity	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)
Diagnostic X-ray & Lab (Outpatient)	$10 per encounter	X-ray and lab in medical office - No charge, deductible does not apply Lab in hospital: 20%	$10 per encounter, deductible does not apply	$10 per encounter, deductible does not apply
MRI, CT, and PET scans	20% up to a maximum of $50 per procedure	$50 per procedure, deductible does not apply	$50 per procedure, deductible does not apply	$50 per procedure, deductible does not apply
Durable Medical Equipment and Corrective Appliances	20%, deductible does not apply	20%	None, deductible does not apply	20%, deductible does not apply
Hearing Aids	None, deductible does not apply; subject to a $1,000 max benefit per device, 1 device per ear and 2 devices every 36 months	None, deductible does not apply; subject to a $1,000 max benefit per device, 1 device per ear and 2 devices every 36 months	None, deductible does not apply; per ear every 36 months	20%, deductible does not apply; 1 device per ear every 36 months
Home Health Care/Nursing Care (at home)	None, deductible does not apply; limited to 100 visits per year	None, deductible does not apply; limited to 100 visits per year	None, deductible does not apply; limited to 130 visits per year	None, deductible does not apply; limited to 130 visits per year
Chiropractor	$15 per visit, deductible does not apply; limited to 20 visits per 12-month period	$20 per visit, deductible does not apply; limited to 20 visits per year	$20 per visit, deductible does not apply; limited to 12 visits per year	$20 per visit, deductible does not apply; limited to 10 visits per year
Physical Therapy (short-term outpatient)	$20 per visit	$20 per visit; limited to 20 visits per year per type of therapy	$20 per visit, deductible does not apply; limited to 20 visits per year per type of therapy	$20 per visit
Speech Therapy (short-term outpatient)	$20 per visit	$20 per visit, limited to 20 visits per year per type of therapy	$20 per visit, deductible does not apply; limited to 20 visits per year per type of therapy	$20 per visit

MEDICAL BENEFITS	KAISER			
	HEALTH PLAN			
REGIONS AVAILABLE	***CA***	***CO***	***NW***	***WA***
	Your Cost	*Your Cost*	*Your Cost*	*Your Cost*
Alcoholism & Drug Addiction				
Inpatient	20%	20%	20%	20%
Outpatient	$20 per visit ($5 for group session), deductible does not apply	$20 per visit ($5 for group session), deductible does not apply	$20 per visit ($10 for group session), deductible does not apply	$20 per visit ($5 for group session), deductible does not apply
Mental Health				
Inpatient Hospital	20%	20%	20%	20%
Outpatient	$20 per visit ($10 for group session), deductible does not apply	$20 per visit ($10 for group session), deductible does not apply	$20 per visit ($10 for group session), deductible does not apply	$20 per visit ($10 for group session), deductible does not apply
Other Covered Services and Supplies Including Infertility Services (contact Kaiser Member Services for coverage details which may vary by State)	Varying cost share may apply	Varying cost share may apply	Varying cost share may apply	Varying cost share may apply

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COMPARISON OF MEDICAL BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2026

PRESCRIPTION DRUG BENEFITS	WESTERN STATES CARPENTERS	KAISER
	PPO PLANS	HMO PLAN
REGIONS AVAILABLE	***PPO Copay Plan: ALL STATES*** ***Bronze Plan: AZ, NM, CO, UT, NV, CA, WA, OR, ID, MT***	***CA & CO & NW & WA***
	Your Cost	*Your Cost*
Calendar Year Deductible	None	None
Calendar Year Out-of-Pocket Maximum (includes deductibles and most copays & coinsurance) (Self-Only / Family)	Network pharmacy or mail service – $1,000 / $2,000 Non-Network pharmacy – None	Medical Benefits Out-of-Pocket Maximum is a combined maximum for medical & prescription drug benefits
Retail Network Pharmacy	30-day supply You pay the lower of the cost of the drug or the copay	30-day supply
Generic	$10; $0 for prescription contraceptives	$10; $0 for prescription contraceptives
Formulary Brand	$40*	$30
Non-Formulary	$60*	Specialty/Brand/Generic copays apply when medically necessary
Specialty	$50	20%, not to exceed $250
Limit on Maintenance Medication at Retail	One refill, then you pay 100% if you continue to have it dispensed at a retail pharmacy	No limit
Mail Order	90-day supply	CA: 100-day supply; CO, NW, WA: 90-day supply
Generic	$25; $0 for prescription contraceptives	$20; $0 for prescription contraceptives
Formulary Brand	$100	$60
Non-Formulary	$150	Specialty/Brand/Generic copays apply when medically necessary

*Note: If a Generic is available, and you or your doctor indicate, “Do not substitute” on the prescription, you will be charged the Brand copay, plus the difference in cost between the Generic and the Brand drug.

WESTERN STATES CARPENTERS HEALTH AND WELFARE PLAN
COMPARISON OF PRESCRIPTION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2026

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DENTAL BENEFITS	**UNITEDHEALTHCARE**	
	DPPO PLAN	
REGIONS AVAILABLE	***ALL STATES***	
	Your Cost	
	In-Network*	Out-of-Network**
Calendar Year Deductible (Individual / Family); does not apply to Diagnostic & Preventive Services	$50 / $150	$50 / $150
Calendar Year Benefit Maximum Per Person	$3,000	$2,000
Orthodontic Lifetime Benefit Maximum	$2,000	
Diagnostic Services		
Periodic Oral Evaluation	$0	50%
Radiographs	$0	50%
Lab and Other Diagnostic Tests	$0	50%
Preventive Services		
Prophylaxis (Cleaning)	$0	50%
Fluoride Treatment (Preventive)	$0	50%
Sealants	$0	50%
Space Maintainers	$0	50%
Basic Services		
Restorations (Amalgams or Composite)	20%	50%
Emergency Treatment/General Services	20%	50%
Simple Extractions	20%	50%
Oral Surgery (incl. surgical extractions)	20%	50%
Periodontics	20%	50%
Endodontics	20%	50%
Major Services		
Inlays/Onlays/Crowns	20%	50%
Dentures and Removable Prosthetics	20%	50%
Fixed Partial Dentures (Bridges)	20%	50%
Orthodontic Services		
Diagnose or correct misalignment of the teeth or bite	20%	50%

* The network percentage of benefits is based on the discounted fees negotiated with the provider.
** The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

WESTERN STATES CARPENTERS HEALTH AND WELFARE PLAN
COMPARISON OF VISION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2026

VISION BENEFITS	VSP
	Vision Plan
REGIONS AVAILABLE	***ALL STATES***
	Your Cost
Exam	$0 copay
Prescription Glasses	Lenses Per Pair: $0 copay, Once Every 12 Months Frames: $150 allowance, Once Every 12 Months Lens Enhancements: Anti-reflective coating, polycarbonate, standard progressives, tints/dyes, and scratch-resistant coating are covered
Contact Lenses	Exam: up to $60 copay Elective contact lenses in lieu of lenses or frames: $150 allowance
Safety Glasses	Benefit includes coverage for a pair of safety glasses for the employee. Employee must be enrolled in the comprehensive plan to get the safety plan benefits. Lenses Per Pair: $0 copay, Once Every 12 Months Frames: Once every 24 Months. $60 frame allowance toward any safety frame from a VSP doctor, or covered in full safety frame from ProTec Eyewear® Collection, or covered in full safety frame from any Visionworks location Lens Enhancements: polycarbonate lenses are covered

Benefit	Contact for Assistance	Benefit Description
CancerNavigator *(PPO Only)*	www.cancernavigator.com/wscarpenters **(213) 657-5282**	**Cancer support program.** Connect directly with an Oncology Nurse Navigator to discuss diagnosis and recommended treatment options, talk through decisions for care, receive support and counseling, and learn which centers and providers are near the patient, in-network, and are well-equipped to treat specific cancers. Program offered at no cost to eligible Participants and Enrolled Dependents.
Sword Health *(PPO Only)*	https://meet.swordhealth.com/westerncarpenters **(888) 346-0476**	**Digital customized physical therapy at home on your schedule.** Targets chronic musculoskeletal pain, pain prevention, and injury avoidance. Program offered at no cost to eligible Participants and Enrolled Dependents.
Nimble Health *(PPO Only)*	www.Nimble-Health.com **(833) 844-8556**	**Concierge program for musculoskeletal conditions (e.g. knee, shoulder, neck).** Offers clinical decision support, care navigation, and concierge scheduling to high quality providers for advanced imaging, pain management, physical therapy, second opinion, or surgery. Program offered at no cost to eligible Participants and Enrolled Dependents.
Virta Health *(PPO Only)*	www.virtahealth.com/join/swc	Guided nutrition program offering support to manage diabetes, reverse Type 2 diabetes or prediabetes, and weight loss. Program offered without cost to eligible Participants and Enrolled Dependents.
ComPsych Carpenters Assistance Program *(PPO & Kaiser)*	www.guidanceresources.com **WEB ID: SWCCAP** **(833) 792-2271**	**Free, confidential mental health assistance, available 24/7.** Offers up to 5 free counseling sessions, per participant per event, with a licensed clinician, in addition to legal and financial resources, and work-life solutions. Program offered at no cost to eligible Participants and Enrolled Dependents.
Western States Carpenters Health Reimbursement Arrangement (HRA) *(PPO & Kaiser)*	**Account balances or Claims:** www.theharrisongrouponline.com/wschra **(855) 972-4721**	Health Reimbursement Arrangement (HRA) for participants working under a Collective Bargaining Agreement that requires contributions to the HRA. HRA balance can be used to pay for eligible health-related expenses (e.g. copays, deductible, and more).