Carpenters Southwest Administrative Corporation

ADMINISTRATIVE OFFICE: 533 S. Fremont Ave. • Los Angeles, CA 90071-1706 • Tel: (213) 386-8590 • Toll Free: (800) 293-1370

www.carpenterssw.org

Active

Comparison of Medical Benefits

For Carpenters in AZ, NM, CO, UT, NV and New Apprentices

2019

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

Anthem PPO Plan Notes: Only “allowable charges” are used in determining benefits under the Anthem PPO Plan. “Allowable Charge” means the customary charge, if incurred with respect to an Eligible Individual while in that status, in the area in which it is incurred, but not exceeding such charge as would have been made in the absence of benefits provided under this Plan, and to the extent an Allowable Charge is limited to a specific dollar amount within the Plan’s benefit provisions, not exceeding the stated dollar limit for the service or supply rendered or obtained. The deductible is the amount of Allowable Charges you need to pay each calendar year before the Plan starts paying Allowable Charges for covered services or supplies. The Plan will pay 100% of Allowable Charges once the amount that any individual or family pays for covered services reaches the Out-of-Pocket Maximum. Refer to the Summary Plan Description booklet for more information.

Non-PPO emergency room visit and emergency outpatient surgery are paid at the PPO benefit level if treatment is due to a medical condition 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 various types of serious harm. Non-PPO inpatient confinement for an emergency is also payable at the PPO level if authorized within 48 hours following admission as an inpatient.

THIS IS ONLY A SUMMARY: The below Plan benefits show only a partial summary of benefits. Please refer to the applicable Evidence of Coverage (EOC) booklet or Summary Plan Description booklet for prior-authorization requirements and specific restrictions, exclusions, and limitations. 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 booklet 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 www.carpenterssw.org. Our website provides useful information on benefits, eligibility rules, links to provider networks, forms for changes in family status and much, much more.

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST
COMPARISON OF MEDICAL AND PRESCRIPTION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2019

Visit us at www.carpenterssw.org

MEDICAL BENEFITS	ANTHEM PPO PLAN				KAISER
	GOLD PLAN		BRONZE PLAN		HMO PLAN
REGIONS AVAILABLE	***ALL STATES***		***AZ, NM, CO, UT, NV***		***CO***
	Your Cost		*Your Cost*		*Your Cost*
	PPO	Non-PPO	PPO	Non-PPO	
Calendar Year Deductible – the deductible applies to all medical benefits unless otherwise stated (Self-Only / Family Max)	$300 / $900	$500 / $1,500	$3,000 / $6,000	$10,000 / $20,000	$300 / $600
Calendar Year Out-of-Pocket Maximum (includes deductibles and most copays & coinsurance) (Self-Only / Family)	$2,500 / $5,000	None except for emergency	$5,600 / $11,200	None except for emergency	$2,500 / $5,000
Hospital					
Inpatient	10%	50%	20%	50%	10%
Outpatient surgery	10%	50% ($5,000 max allowable per session)	20%	50% ($5,000 max allowable per session)	10%
Emergency room (copay waived if admitted)	$250 per visit then 10%	$250 per visit then 10% (50% if not true emergency)	$250 per visit then 20%	$250 per visit then 20% (50% if not true emergency)	10%
Ambulance Services	$50 per trip, deductible does not apply	$50 per trip, deductible does not apply	$50 per trip, deductible does not apply	$50 per trip, deductible does not apply	$150 per trip, deductible does not apply
Extended Care Facility	None for first 30 days, 10% thereafter for room and board and 10% for other services, 180-day limit per disability		None for first 30 days, 20% thereafter for room and board and 20% for other services, 180-day limit per disability		10%, deductible does not apply; 100-day limit per calendar year
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, deductible does not apply	50%	None, deductible does not apply	Not Covered	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	50%	None, deductible does not apply	Not Covered	None, deductible does not apply
Physician					
Surgery – Inpatient	10%	50%	20%	50%	10%
Surgery – Outpatient	10%	50%	20%	50%	10%
Hospital Visits	10%	50%	20%	50%	10%
Office Visits	10%	50%	20%	50%	$10 for non-specialist, $20 for specialist, deductible does not apply
Second Surgical Opinion from a Specialist	None up to $150, deductible does not apply	None up to $150, deductible does not apply	None up to $150, deductible does not apply	None up to $150, deductible does not apply	$20 per visit, deductible does not apply (within Kaiser)
Maternity	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit at 100% if PPO); No coverage for children		Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit at 100% if PPO); No coverage for children		Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)
Diagnostic X-ray & Lab (Outpatient)	10%	50%	20%	50%	$10 per encounter; $50 for MRI, CT, and PET scans; deductible does not apply
Durable Medical Equipment and Corrective Appliances	10%	50%	20%	50%	20%, deductible does not apply

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST
COMPARISON OF MEDICAL AND PRESCRIPTION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2019

Visit us at www.carpenterssw.org

MEDICAL BENEFITS	ANTHEM PPO PLAN				KAISER
	GOLD PLAN		BRONZE PLAN		HMO PLAN
REGIONS AVAILABLE	***ALL STATES***		***AZ, NM, CO, UT, NV***		***CO***
	Your Cost		*Your Cost*		*Your Cost*
	PPO	Non-PPO	PPO	Non-PPO	
Home Health Care/Nursing Care (at home)	10%	50%	20%	50%	None, deductible does not apply; limited to 100 visits per accumulation period
Chiropractor	All charges in excess of $10 benefit per visit, limited to 24 visits per calendar year		All charges in excess of $10 benefit per visit, limited to 24 visits per calendar year		$15 per visit, deductible does not apply; limited to 20 visits per calendar year
Physical Therapy (short-term outpatient)	10%	50%	20%	50%	$10 per visit, deductible does not apply
	PPO & Non-PPO limited to 20 visits per calendar year		PPO & Non-PPO limited to 20 visits per calendar year		
Speech Therapy (short-term outpatient)	10%	50%	20%	50%	$10 per visit, deductible does not apply
	PPO & Non-PPO limited to 130 visits per lifetime		PPO & Non-PPO limited to 130 visits per lifetime		
Alcoholism & Drug Addiction					
Inpatient	10%	50%	20%	50%	10%
Outpatient	10%	50%	20%	50%	$10 per visit ($5 for group session), deductible does not apply
Mental Health					
Inpatient Hospital	10%	50%	20%	50%	10%
Outpatient	10%	50%	20%	50%	$10 per visit ($5 for group session), deductible does not apply
Other Covered Services and Supplies	10%	50%	20%	50%	Varying copays and coinsurances may apply

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST
COMPARISON OF MEDICAL AND PRESCRIPTION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2019

Visit us at www.carpenterssw.org

PRESCRIPTION DRUG BENEFITS	ANTHEM PPO PLAN	KAISER
	GOLD AND BRONZE PLANS	HMO PLAN
REGIONS AVAILABLE	***Gold: ALL STATES*** ***Bronze: AZ, NM, CO, UT, NV***	***CO***
	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*	Not covered unless medically necessary
Specialty	$50	$30
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	90-day supply
Generic	$25; $0 for prescription contraceptives	$20; $0 for prescription contraceptives
Formulary Brand	$100	$60
Non-Formulary	$150	Not covered unless 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.