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

2020

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, 2020

Visit us at www.carpenterssw.org

MEDICAL BENEFITS	ANTHEM		KAISER
	PPO PLAN		HMO PLAN
REGIONS AVAILABLE	***ALL STATES***		***CA & CO***
	Your Cost		*Your Cost*
	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	$300 / $600 - Hospital Deductible Only
Calendar Year Out-of-Pocket Maximum (includes deductibles and most copays & coinsurance) (Self-Only / Family)	$2,500 / $5,000	None except for emergency	$2,500 / $5,000
Hospital			
Inpatient	10%	50%	10%
Outpatient surgery	10%	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)	10%
Ambulance Services	$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		10%, deductible does not apply; 100-day limit 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, deductible does not apply	50%	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
Physician			
Surgery – Inpatient	10%	50%	10%
Surgery – Outpatient	10%	50%	10%
Hospital Visits	10%	50%	10%
Office Visits	10%	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	$20 per visit, deductible does not apply (within Kaiser)

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MEDICAL BENEFITS	ANTHEM		KAISER
	PPO PLAN		HMO PLAN
REGIONS AVAILABLE	***ALL STATES***		***CA & CO***
	Your Cost		*Your Cost*
	PPO	Non-PPO	
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 with no copay)
Diagnostic X-ray & Lab (Outpatient)	10%	50%	$10 per encounter; $50 for MRI, CT, and PET scans; deductible does not apply
Durable Medical Equipment and Corrective Appliances	10%	50%	20%, deductible does not apply
Hearing Aids	10%; subject to a $1,000 max benefit per ear every 24 months		None; subject to a $1,000 max benefit per device, one device per ear and 2 devices every 36 months, deductible does not apply
Home Health Care/Nursing Care (at home)	10%	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		$15 per visit, deductible does not apply; limited to 20 visits per calendar year
Physical Therapy (short-term outpatient)	10%	50%	$10 per visit, deductible does not apply
	PPO & Non-PPO limited to 20 visits per calendar year		
Speech Therapy (short-term outpatient)	10%	50%	$10 per visit, deductible does not apply
	PPO & Non-PPO limited to 130 visits per lifetime		
Alcoholism & Drug Addiction			
Inpatient	10%	50%	10%
Outpatient	10%	50%	$10 per visit ($5 for group session), deductible does not apply
Mental Health			
Inpatient Hospital	10%	50%	10%
Outpatient	10%	50%	$10 per visit ($5 for group session), deductible does not apply
Other Covered Services and Supplies	10%	50%	Varying copays and coinsurances may apply

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FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2020

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PRESCRIPTION DRUG BENEFITS	ANTHEM	KAISER
	PPO PLAN	HMO PLAN
REGIONS AVAILABLE	***ALL STATES***	***CA & 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	CA: 100-day supply; CO: 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.

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Comparison of Dental Benefits

2020

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SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST
COMPARISON OF DENTAL BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2020

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DENTAL BENEFITS	UNITEDHEALTHCARE				
	DPPO PLAN		DIRECT COMPENSATION		IN-NETWORK ONLY
REGIONS AVAILABLE	***ALL STATES***		***CA In-Network Coverage Only***	***NV In- and Out-of-Network***	***ALL OTHER STATES*****
	Your Cost		*Your Cost*	*Your Cost at a Network Provider*	*Your Cost*
	In-Network	Out-of-Network			
Calendar Year Deductible (Individual / Family); does not apply to Diagnostic & Preventive Services	$50 / $150	$50 / $150	None	None	None
Calendar Year Benefit Maximum Per Person	$2,000		None	None	$5,000
Orthodontic Lifetime Benefit Maximum	$2,000		Not Applicable	Not Applicable	$2,000
Diagnostic & Preventive Services					
X-Rays, Intraoral, full mouth series with bitewings (D0210)	$0	50% ($0 in TX*)	$0	$0	$0
X-Rays, bitewings, two films (D0272)	$0	50% ($0 in TX*)	$0	$0	$0
Teeth cleaning (D1110 & D1120)	$0	50% ($0 in TX*)	$0	$0	$0
Space maintainer, fixed, bilateral (D1515)	$0	50% ($0 in TX*)	$0	$0	$0
Restorations					
Amalgam filling, one surface, primary or permanent tooth (D2140)	50%	50%	$5	$5	$5
Amalgam filling, three surfaces, primary or permanent tooth (D2160)	50%	50%	$10	$10	$10
Porcelain crown / base metal (D2751)	50%	50%	$90	$90	$90
Full cast crown / base metal (D2791)	50%	50%	$90	$90	$90
Full cast noble metal crown (D2792)	50%	50%	$100	$100	$100
Periodontics					
Gingivectomy, per quadrant (D4210)	50%	50%	$10	$10	$10
Scaling and root planing, per quadrant (D4341)	50%	50%	$5	$5	$5
Endodontics					
Root canal, anterior (D3310)	50%	50%	$15	$15	$15
Root canal, bicuspid (D3320)	50%	50%	$20	$20	$20
Root canal, molar (D3330)	50%	50%	$60	$60	$60
Apicoectomy per tooth (D3410)	50%	50%	$15	$15	$15
Prosthetics					
Complete upper denture (D5110)	50%	50%	$140	$140	$140
Complete lower denture (D5120)	50%	50%	$140	$140	$140
Partial denture, upper, cast metal (D5213)	50%	50%	$140	$140	$140
Partial denture, lower, cast metal (D5214)	50%	50%	$140	$140	$140

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DENTAL BENEFITS	UNITEDHEALTHCARE				
	DPPO PLAN		DIRECT COMPENSATION		IN-NETWORK ONLY
REGIONS AVAILABLE	***ALL STATES***		***CA In-Network Coverage Only***	***NV In- and Out-of-Network***	***ALL OTHER STATES*****
	Your Cost		*Your Cost*	*Your Cost at a Network Provider*	*Your Cost*
	In-Network	Out-of-Network			
Oral Surgery					
Extraction, erupted tooth (D7140)	50%	50%	$5	$5	$5
Surgical extraction, erupted tooth (D7210)	50%	50%	$5	$5	$5
Surgical extraction, complete bony impaction (D7240)	50%	50%	$15	$15	$15
Adjunctive General Services					
Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment (D9243)	50%	50%	$5	$5	$5
Occlusal guard (D9940)	50%	50%	$15	$15	$15
External teeth bleaching for home application, per arch (D9972)	50%	50%	$125	$125	$125
Specialist Consultation (D9310)	50%	50%	$0	$0	$0
Orthodontic - Full banded treatment (not including diagnostic x-rays)					
Children	50%	50%	$1,500	$1,500	50%
Age Limit	up to age 19	up to age 19	up to age 19	up to age 19	up to age 19
Adult	50%	50%	$1,500	$1,500	50%

* Members in the following states pay $0 for Out-of-Network Diagnostic and Preventive Services: Alabama, Louisiana, Mississippi, and Texas.
** The following states are not covered by the UHC In-Network Only plan: Alaska, Alabama, Arkansas, Connecticut, Georgia, Hawaii, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maryland, Maine, Missouri, Mississippi, Montana, New Mexico, North Carolina, North Dakota, Oklahoma, Texas, and Vermont.