Active

2024 Health Plan Benefits "At a Glance"

Carpenters Southwest Administrative Corporation | 533 South Fremont Avenue, Los Angeles, CA 90071-1706 | Tel: 213-386-8590 | Toll Free: 800-293-1370

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 www.carpenterssw.org.

Southwest Carpenters Medical PPO Plan Notes: Only “allowable charges” are used in determining benefits under the Southwest Carpenters Medical 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 book for more information.

Out-of-network emergency room visit and emergency outpatient surgery are paid at the in-network 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. Out-of-network inpatient confinement for an emergency is also payable at the in-network 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) document or Summary Plan Description book 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 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 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 BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2024

Visit us at www.carpenterssw.org

MEDICAL BENEFITS	SOUTHWEST CARPENTERS				KAISER
	PPO COPAY PLAN		BRONZE PLAN		HMO PLAN
REGIONS AVAILABLE	***ALL STATES***		***BY AGREEMENT***		***CA & CO***
	Your Cost		*Your Cost*		*Your Cost*
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Calendar Year Deductible – the deductible applies to all medical benefits unless otherwise stated (Self-Only / Family Max)	None	$500 / $1,500	$3,000 / $6,000	$10,000 / $20,000	$250 / $500
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	$3,000 / $6,000
Hospital					
Inpatient	$500 per admission	50%	20%	50%	20%
Outpatient surgery	$250 per surgery	50% ($5,000 max allowable per session)	20%	50% ($5,000 max allowable per session)	20%
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)	20%
Urgent Care	$50 per visit	50%	20%	20%	$20 per visit, deductible does not apply
Ambulance Services	$100 per trip	$100 per trip, deductible does not apply	$50 per trip, deductible does not apply	$50 per trip, deductible does not apply	$150 per trip
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		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	50%	None, deductible does not apply	50%	None for primary care physician, specialist and well-baby/prenatal care
Physical Exam, Screenings, Laboratory and Other Tests & Immunizations	None	50%	None, deductible does not apply	50%	None
Physician					
Surgery – Inpatient	None for non-specialist, $30 for specialist	50%	20%	50%	20%
Surgery – Outpatient	None for non-specialist, $30 for specialist	50% ($3,500 max allowable per session)	20%	50% ($3,500 max allowable per session)	20%
Hospital Visits	None for non-specialist, $30 for specialist	50%	20%	50%	20%
Office Visits	$15 for non-specialist, $30 for specialist	50%	20%	50%	$20 for non-specialist, $30 for specialist
Second Surgical Opinion from a Specialist	$30 per visit	50%	None up to $150, deductible does not apply	None up to $150, deductible does not apply	$30 per visit (within Kaiser)

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MEDICAL BENEFITS	SOUTHWEST CARPENTERS				KAISER
	PPO COPAY PLAN		BRONZE PLAN		HMO PLAN
REGIONS AVAILABLE	*ALL STATES*		*BY AGREEMENT*		*CA & CO*
	Your Cost		*Your Cost*		*Your Cost*
	In-Network	Out-of-Network	In-Network	Out-of-Network	
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 children		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 children		Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)
Diagnostic X-ray & Lab (Outpatient)	$30 per visit	50%	20%	50%	$10 per encounter; 20% up to a maximum of $50 per procedure for MRI, CT, and PET scans
Durable Medical Equipment and Corrective Appliances	$30 per item	50%	20%	50%	20%, deductible does not apply
Hearing Aids	$30; subject to a $1,000 max benefit per ear every 24 months	50%; subject to a $1,000 max benefit per ear every 24 months	20%; subject to a $1,000 max benefit per ear every 24 months		None; subject to a $1,000 max benefit per device, 1 device per ear and 2 devices every 36 months
Home Health Care/Nursing Care (at home)	$30 per visit	50%	20%	50%	None, deductible does not apply; limited to 100 visits per year
Chiropractor	$15 per visit	50%	All charges in excess of $10 benefit per visit, limited to 24 visits per year		CA: $15 per visit; CO: $20 per visit; limited to 20 visits per year
	In- & Out-of-Network limited to 24 visits per year				
Physical Therapy (short-term outpatient)	$15 per visit	50%	20%	50%	$20 per visit
	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)	$15 per visit	50%	20%	50%	$20 per visit
	In- & Out-of-Network limited to 130 visits per lifetime		In- & Out-of-Network limited to 130 visits per lifetime		
Alcoholism & Drug Addiction					
Inpatient	$500 per visit	50%	20%	50%	20%
Outpatient	$15 per visit	50%	20%	50%	$20 per visit (CA: $5 for group session; CO: $10 for group session), deductible does not apply
Mental Health					
Inpatient Hospital	$500 per visit	50%	20%	50%	20%
Outpatient	$15 per visit	50%	20%	50%	$20 per visit ($10 for group session), deductible does not apply
Other Covered Services and Supplies	Varying cost share may apply	50%	20%	50%	Varying cost share may apply

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST
COMPARISON OF PRESCRIPTION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2024

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PRESCRIPTION DRUG BENEFITS	**SOUTHWEST CARPENTERS**	**KAISER**
	PPO PLANS	**HMO PLAN**
REGIONS AVAILABLE	***PPO Copay Plan: ALL STATES*** ***Bronze Plan: BY AGREEMENT***	***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*	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: 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.

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST
COMPARISON OF DENTAL BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2024

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DENTAL BENEFITS **Dental Benefits are not offered on the Bronze Plan**	**UNITEDHEALTHCARE**				
	DPPO PLAN		**DIRECT COMPENSATION**		**IN-NETWORK ONLY**
REGIONS AVAILABLE	***ALL STATES***		***CA In-Network Coverage Only***	***NV In-Network Coverage Only***	***ALL OTHER STATES*****
	Your Cost		*Your Cost*	*Your Cost*	*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	$3,000	$2,000 ($3,000 in TX*)	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 (D1520)	$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

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COMPARISON OF DENTAL BENEFITS
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DENTAL BENEFITS **Dental Benefits are not offered on the Bronze Plan**	**UNITEDHEALTHCARE**				
	DPPO PLAN		**DIRECT COMPENSATION**		**IN-NETWORK ONLY**
REGIONS AVAILABLE	***ALL STATES***		***CA In-Network Coverage Only***	***NV In-Network Coverage Only***	***ALL OTHER STATES*****
	Your Cost		*Your Cost*	*Your Cost*	*Your Cost*
	In-Network	Out-of-Network			
Partial denture, lower, cast metal (D5214)	50%	50%	$140	$140	$140
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 (D9943)	50%	50%	$15	$15	$15
External teeth bleaching for home application, per arch (D9972)	Not covered	Not covered	$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 have a $3,000 Out-of-Network Calendar Year Benefit Maximum Per Person and 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.

VISION BENEFITS **Vision Benefits are not offered on the Bronze Plan**	**UNITEDHEALTHCARE** **Vision Plan**
REGIONS AVAILABLE	***ALL STATES***
	Your Cost
Exam	$10 copay
Prescription Glasses	$20 copay for materials Lenses Per Pair: Once Every 12 Months Frames: Once Every 24 Months
Contact Lenses	$20 copay, Once Every 12 Months
Safety Glasses	Benefit includes coverage for a pair of safety glasses for the employee. The benefit includes $60 retail frame allowance for safety frames, polycarbonate lenses and side shields are covered under this benefit. This is an in network only benefit. Employee must be enrolled in the comprehensive plan to get the safety plan benefits.