SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST
COMPARISON OF MEDICAL, PRESCRIPTION AND VISION PLANS
FOR ACTIVE ARIZONA, UTAH, NEW MEXICO and TEXAS PARTICIPANTS

DESCRIPTION OF BENEFITS	FEE-FOR-SERVICE PLAN	UNITED HEALTHCARE CHOICE EPO	UNITED HEALTHCARE CHOICE PLUS	SELECT HEALTH HMO
REGIONS AVAILABLE	***ALL STATES***	***AZ Only***	***NM ONLY** (and parts of CO&TX)*	***UT ONLY***
	(What the Plan Pays)	*(Your Cost)*	*(Your Cost)*	*(Your Cost)*
MEDICAL BENEFITS				
CALENDAR YEAR DEDUCTIBLE	$250 per person, maximum of $750 per family	$100 per person, maximum of $200 per family	$100 per person, maximum of $200 per family	$100 per person, maximum of $200 per family
OVERALL LIFETIME MAXIMUM	None	None	None	None
OVERALL CALENDAR YEAR MAXIMUM	$1,000,000 per person	None	None	None
Hospital	*See directory*	*See directory*	*See directory*	*See directory*
In-patient	**Contracting** facility, 85% of allowable charges **Non-contracting** facility, 55% of allowable charges	$150 per admission after deductible is satisfied	$150 per admission after deductible is satisfied	$150 per admission after deductible is satisfied
Out-patient Surgery	**Contracting** facility, 85% of allowable charges **Non-Contracting** facility, 55% (Maximum allowable $5,000 per operative session)	$30 per visit or procedure after deductible is satisfied ($15 for non-specialist)	$30 per visit or procedure after deductible is satisfied ($15 for non-specialist)	None after deductible is satisfied
Out-patient Emergency Care	$100 per visit (waived if admitted), then… **Contracting** facility, 85% of allowable charges **Non-contracting** facility, 85% of allowable charges (55% if not true emergency)	$100 per visit (waived if admitted)	$100 per visit (waived if admitted)	$100 per visit after deductible is satisfied ($150 per visit if a non-network facility is used)
Other Hospital Out-patient Services	**Contracting** facility, 85% **Non-contracting** facility, 55%, (maximum allowable $3,500)	None after deductible is satisfied	None after deductible is satisfied	None after deductible is satisfied
Ambulance Services	Maximum allowable of $700 base fee and $15 per mile for ground and $5,000 base fee and $70 per mile for air	None after deductible is satisfied	$50 per trip for ground, $100 per trip for air (no deductible)	$50 per trip for ground, $100 per trip for air, after deductible is satisfied

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REGIONS AVAILABLE	***ALL STATES***	***AZ Only***	***NM ONLY** **(and parts of CO&TX)***	***UT ONLY***
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Extended Care Facility	100% for first 30 days, 85% thereafter for room and board and 85% for other services, 180 day limit per disability	None after deductible is satisfied; limited to 100 days per calendar year	None after deductible is satisfied; limited to 100 days per calendar year	$150 per admission after deductible is satisfied; limited to 100 days 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	If performed by a **contracting** provider, no deductible, 100% of allowable charges By a **non-contracting** provider, 55% of allowable charges (subject to deductible)	$15 for primary care physician $30 for specialist	$15 for primary care physician $30 for specialist	$15 for primary care physician $30 for specialist
Physical Exam, Laboratory and Other Tests & Immunizations	If performed by a **contracting** provider, no deductible, 100% of allowable charges By a **non-contracting** provider, 55% of allowable charges (subject to deductible)	None	None	None
Physician				
Surgery – In-Patient	If performed by a **contracting** physician, 85% of allowable charges By a **non-contracting** physician, 55% of allowable charges	None after deductible and hospital inpatient co-pays are satisfied	None after deductible and hospital inpatient co-pays are satisfied	None after deductible and hospital inpatient co-pays are satisfied

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Surgery – Out-Patient	If performed by a **contracting** physician, 85% of allowable charges By a **non-contracting** physician, 55% of allowable charges	**$30 per visit or procedure after** **Deductible is satisfied** **($15 for non-specialist)**	**$30 per visit or procedure after** **Deductible is satisfied** **($15 for non-specialist)**	None after deductible is satisfied
Hospital, Office & Home Visits	If rendered by a **contracting** physician, 85% of allowable charges By a **non-contracting** physician, 55% of allowable charges	None for hospital and home visits; $15 for non-specialist office visit $30 for specialist	None for hospital and home visits; $15 for non-specialist office visit $30 for specialist	None for hospital visits; $15 for non-specialist office visit $30 for specialist Home visits not covered
Second Surgical Opinion	100% up to $150 (**contracting** or **non-contracting** provider)	$30 per visit	$30 per visit	$30 per visit
Maternity (Female Employee or Spouse)	Same as any illness	Initial visit only - $15 for non-specialist, $30 for specialist	Initial visit only - $15 for non-specialist, $30 for specialist	None after deductible is satisfied
Diagnostic X-ray & Laboratory	If performed by a **contracting** provider, 85% of allowable charges By a **non-contracting** provider, 55% of allowable charges	None after deductible is satisfied	None after deductible is satisfied	None for routine tests; $100 per procedure for complex tests such as CAT scans, MRIs and PET scans after deductible is satisfied
Durable Medical Equipment and Corrective Appliances	If supplied by a **contracting** provider, 85% of allowable charges By a **non-contracting** provider, 55% of allowable charges	None after deductible is satisfied; some items are subject to a $2,500 calendar year maximum	None after deductible is satisfied; some items are subject to a $2,500 calendar year maximum	None after deductible is satisfied

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REGIONS AVAILABLE	***ALL STATES***	***AZ Only***	***NM ONLY*** ***(and parts of CO&TX)***	***UT ONLY***
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Home Health Care/ Nursing Care (at home)	By a **contracting** provider, 85% of allowable charges By a **non-contracting** provider 55% (maximum allowable charge is $120 per visit for a registered nurse and $60 per visit for a LPN or LVN)	$15 per visit; limited to 100 visits per calendar year	$15 per visit; limited to 100 visits per calendar year	$15 per visit after deductible is satisfied
Chiropractor	$10 benefit per visit Limit of 24 visits per calendar year for contracting and non-contracting providers combined	$30 per visit; limited to 20 visits per calendar year	$30 per visit; limited to 20 visits per calendar year	$30 per visit; limited to 20 visits per calendar year
Physical Therapy (short-term out-patient)	By a **contracting** provider, 85% of allowable charges By a **non-contracting** provider, 55% of allowable charges Limit of 20 visits per calendar year for contracting and non-contracting providers combined	$30 per visit; limited to 20 visits per calendar year	$30 per visit after deductible is satisfied; limited to 20 visits per calendar year	$30 per visit after deductible is satisfied; limited to 20 visits per calendar year
Speech Therapy (short-term out-patient)	By a **contracting** provider, 85% of allowable charges By a **non-contracting** provider, 55% Limit of 130 visits per lifetime for contracting and non-contracting providers combined	$30 per visit; limited to 20 visits per calendar year	$30 per visit after deductible is satisfied; limited to 20 visits per calendar year	$30 per visit after deductible is satisfied; limited to 20 visits per calendar year

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REGIONS AVAILABLE	***ALL STATES***	***AZ Only***	***NM ONLY*** ***(and parts of CO&TX)***	***UT ONLY***
	(What the Plan Pays)	*(Your Cost)*	*(Your Cost)*	*(Your Cost)*
Alcoholism & Drug Addiction				
In-Patient	By a **contracting** provider, 80% of allowable charges By a **non-contracting** provider, 55% of allowable charges Limit of 31 days per calendar year and two episodes of confinement per lifetime for contracting and non-contracting providers combined	$150 per admission; limited to 30 days per calendar year; prior authorization required	$150 per admission; limited to 30 days per calendar year; prior authorization required	$150 per admission after deductible is satisfied
Out-Patient	By a **contracting** provider, 80% of allowable charges By a **non-contracting** provider, 55% of allowable charges Limit of 60 visits per calendar year for contracting and non-contracting providers combined	$30 per visit after deductible is satisfied; limited to 20 visits per calendar year; prior authorization required	$30 per visit after deductible is satisfied; limited to 20 visits per calendar year; prior authorization required	$30 per visit
Nervous & Mental Condition				
In-Patient Hospital	50% of allowable charges up to a maximum of 31 days per calendar year, for full time confinement and pre-authorized partial confinement combined	$150 per admission after deductible is satisfied; limited to 30 days per calendar year	$150 per admission after deductible is satisfied; limited to 30 days per calendar year	See alcoholism and drug addiction. Combined benefit of mental and chemical dependency

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REGIONS AVAILABLE	***ALL STATES***	***AZ Only***	***NM ONLY** (and parts of CO&TX)*	***UT ONLY***
	(What the Plan Pays)	*(Your Cost)*	*(Your Cost)*	*(Your Cost)*
Out-Patient Physician Only	By a **contracting** provider 80% of allowable charges, By a **non-contracting provider**, 55% of allowable charges Limit of 60 visits per calendar year for contracting and non-contracting providers combined (no benefits for out-patient facility charges)	$30 per visit after deductible is satisfied; limited to 20 visits per calendar year	$30 per visit after deductible is satisfied; limited to 20 visits per calendar year	See alcoholism and drug addiction; Combined benefit of mental and chemical dependency
Other Covered Services and Supplies	By a **contracting** provider 85% of allowable charges, By a **non-contracting provider**, 55% of allowable charges	Varying co-pays may apply (see EOC)	Varying co-pays may apply (see EOC)	Varying co-pays may apply (see EOC)

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PRESCRIPTION DRUGS

(no annual deductible)

When Obtained at Participating Pharmacy (all plans have mandatory generic substitution and formulary management programs)

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REGIONS AVAILABLE	***ALL STATES***	***AZ Only***	***NM ONLY*** ***(and parts of CO&TX)***	***UT ONLY***
	(Your Cost)	*(Your Cost)*	*(Your Cost)*	*(Your Cost)*
RETAIL (30 day supply)	Using Medco Card - You pay the lower of the cost of the drug or the co-pay			
Generic	$10	$10	$10	$10
Formulary Brand	$30*	$30	$30	$30*
Non-Formulary	$50*	$30 (some drugs may require prior authorization)	$30 (some drugs may require prior authorization)	$50*
Limit on Maintenance (Long term) Medication at Retail	After the 2nd purchase of a long term medication, you pay 100% of the discounted cost of the medication if you continue to have it dispensed at a retail pharmacy	None	None	None
MAIL (90 day supply)				
Generic	$25	$20	$20	$20
Formulary Brand	$75*	$60	$60	$60
Non-Formulary	$125*	$60 (some drugs may require prior authorization)	$60 (some drugs may require prior authorization)	$150
**Note: If a generic is available, and you or your doctor indicate "Do not substitute" on the prescription, you will be charged the brand co-payment, plus the difference in cost between the generic and the brand named drug.*				
Prescriptions Obtained at a Non-Participating Pharmacy	Reimbursed at 90% of contracted rates as if purchased at a participating pharmacy, (after a $50 co-payment per prescription)	You are responsible for any difference between the charge and what would have been paid at a network pharmacy	You are responsible for any difference between the charge and what would have been paid at a network pharmacy	Pay full price, submit receipt for reimbursement for covered drugs

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VISION CARE **(no annual deductible)**	**VISION CARE PLAN PROVIDED BY UNITEDHEALTHCARE VISION** **(for all participants regardless of medical option selected)**	
	UnitedHealthcare Vision Customer Service (800) 638-3120 Provider Locator (800) 839-3242 www.myuhcspecialtybenefits.com	
	In Network Member Co-Payments: ***(What you pay)***	***Out of Network Benefits*** ***(You will be reimbursed up to…)***
Exam	$10 co-pay	$40
Lenses - per pair	$20 for materials (one time co-pay applies to all materials, whether frame and lenses, frame only, or lenses only)	$40 single vision $60 bifocal $80 trifocal $125 lenticular
Frames	Included in the $20 for materials (Not all frames are covered in full. If you pick a non selection frame, the wholesale or retail allowance would apply.)	$65
Contact Lenses (once every 12 months)	Instead of lenses, at the $20 co-pay, you may select contact lenses. UnitedHealthcare Vision offers a wide variety of contacts from many leading manufacturers. Four boxes (12 pairs) of covered disposables are included when obtained from a Network Provider. Non-selection contacts are available at a $125 total allowance (see UnitedHealthcare Vision brochure for details)	$125 elective $210 necessary (Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with glasses; with certain conditions of anisometropia and keratoconus.)
Frequency Exam Lenses Frames	Once every 12 months Once every 12 months Once every 24 months	

IMPORTANT: All new or reinstated eligibles must enroll in an HMO/EPO plan unless they reside outside an HMO/EPO service area until the next scheduled open enrollment period.

PPO Networks: For a listing of participating Fee-For-Service medical providers in California visit www.bluecrossca.com. For services rendered outside of California, the provider network is Anthem Blue Cross BlueCard at www.anthem.com . Once at www.anthem.com please select the state where services will be rendered. Or you can dial 1-800-810-BLUE.

FFS Notes: When the total of certain allowable charges incurred by a Fee-for-Service member reaches $30,000 in a year, some benefit percentages will increase to 100% for allowable charges incurred during the remainder of that year for that person.

The term "allowable charges" has a specific meaning under the Fee-For-Service Plan. Refer to the Summary Plan Description booklet for the definition of allowable charges.

Non-PPO emergency room visit and emergency out-patient surgery are paid at the PPO benefit level if treatment is due to "A sudden unexpected onset of a medical condition, not normally treatable in the provider's office that manifests itself by acute symptoms of enough severity that urgent and immediate attention is required without regard to the hour of the day or night to prevent significant impairment in bodily functions or serious and/or permanent damage to any bodily organ or part." Non-PPO inpatient confinement for an emergency is also payable at the PPO level if authorized within 48 hours following admission as an inpatient.

HMO/EPO Note: The above HMO/EPO Plan benefits show only a partial summary of benefits. Please refer to the HMO/EPO Evidence of Coverage (EOC) for prior-authorization requirements and specific restrictions, exclusions, and limitations. The co-payments 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 or EPO Plan. All charges associated with non-covered services or denied claims will be the member's responsibility.

This benefit summary has been prepared for a comparison of benefits only. Refer to your Summary Plan Description booklet (SPD) or EPO Evidence of Coverage document for details. You may also visit us on-line at www.carpenterssw.org.

(Rev. 9/10/11 kh)