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

Comparison of Benefit Options for Nevada Active Southwest Carpenters 2011

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 for details. You may also visit us on-line at www.carpenterssw.org

Arizona
Satellite Office
4547 W. McDowell Rd., Ste. 6
Phoenix, AZ 85035-4124
(602) 352-6805

Nevada
Satellite Office
980 Kelly Johnson Dr., Ste. 180
Las Vegas, NV 89119-3722
(702) 851-4510 • (800) 501-0210

New Mexico
Satellite Office
3900 A Pan American Freeway, NE Ste. 120
Albuquerque, NM 87107-4747
(505) 266-8869

Utah
Satellite Office
8149 S. Welby Park Drive
West Jordan, UT 84088-5948
(801) 282-6528

SOUTHWEST CARPENTERS HEALTH & WELFARE TRUST • SOUTHWEST CARPENTERS PENSION TRUST • SOUTHWEST CARPENTERS VACATION TRUST • SOUTHWEST CARPENTERS TRAINING FUND

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SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST
COMPARISON OF MEDICAL, PRESCRIPTION AND VISION OPTIONS
FOR ALL ACTIVE NEVADA PARTICIPANTS

DESCRIPTION OF BENEFITS	FEE-FOR-SERVICE PLAN	HEALTH PLAN OF NEVADA HMO	HOMETOWN HEALTH HMO
REGIONS AVAILABLE	***ALL STATES***	***NV ONLY** (and parts of CA&AZ)*	***NO. NV ONLY***
	(What the Plan Pays)	*(Your Cost)*	*(Your Cost)*
MEDICAL BENEFITS			
CALENDAR YEAR DEDUCTIBLE	$250 per person, maximum of $750 per family	$100 per person	$100 per person
LIFETIME MAXIMUM	None	None	None
Hospital	*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	$400 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)	$15 per visit after deductible is satisfied ($100 for anesthesia services)	$250 per visit after deductible is satisfied
Out-patient Emergency Room 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 (not waived if admitted)
Other Hospital Out-patient Services	**Contracting** facility, 85% **Non-contracting** facility, 55%, (maximum allowable $3,500)	$15 per visit 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	$50 per ground trip and $100 per air/water trip after deductible is satisfied	$100 per ground trip and $200 per air/water trip after deductible is satisfied
Extended Care Facility	100% for first 30 days and 85% thereafter for room and board and 85% for other services, 180 day limit per disability	None; limited to 100 days per calendar year	$400 per admission; limited to 30 days per calendar year

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DESCRIPTION OF BENEFITS	FEE-FOR-SERVICE PLAN	HEALTH PLAN OF NEVADA HMO	HOMETOWN HEALTH HMO
REGIONS AVAILABLE	***ALL STATES***	***NV ONLY** (and parts of CA&AZ)*	***NO. NV ONLY***
	(What the Plan Pays)	*(Your Cost)*	*(Your Cost)*
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	No deductible, 100% of allowable charges	$15 for primary care physician $30 for specialist	$30 for primary care physician $50 for specialist
Physical Exam	No deductible, 100% of allowable charges	None	None
Laboratory and Other Tests	No deductible, 100% of allowable charges	None	None
Immunizations	No deductible, 100% of allowable charges	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 is satisfied	None after deductible is satisfied
Surgery – Out-Patient	If performed by a **contracting** physician, 85% of allowable charges By a **non-contracting** physician, 55% of allowable charges	Office visit co-pay or outpatient facility co-pay applies depending on where services are rendered	Office visit co-pay or outpatient facility co-pay applies depending on where services are rendered
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 in-patient visit, $15 for non-specialist office visit, $30 for specialist or home visit after deductible is satisfied	None for in-patient visit, $30 for non-specialist office and home visits, $50 for specialist visit after deductible is satisfied
Second Surgical Opinion	100% up to $150 (**contracting** or **non-contracting** provider)	$30 per visit after deductible is satisfied	$50 per visit after deductible is satisfied

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REGIONS AVAILABLE	***ALL STATES***	***NV ONLY*** ***(and parts of CA&AZ)***	***NO. NV ONLY***
	(What the Plan Pays)	*(Your Cost)*	*(Your Cost)*
Maternity (Female Employee or Spouse)	Same as any illness	Same as any illness	Same as any illness
Diagnostic X-ray & Laboratory (out-patient)	If performed by a **contracting** provider, 85% of allowable charges By a **non-contracting** provider, 55% of allowable charges	None for routine tests; $100 per procedure for complex tests such as CAT scans, MRIs and PET scans after deductible is satisfied	None for routine tests; $200 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	None after deductible is satisfied for durable medical equipment; $25 per corrective appliance after deductible is satisfied
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 after deductible is satisfied; limited to 100 visits per calendar year	$30 per visit after deductible is satisfied
Chiropractor	By a **contracting** provider, 85% of allowable charges By a **non-contracting** provider, 55% of allowable charges Limit of 24 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	$50 per visit after deductible is satisfied; 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 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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DESCRIPTION OF BENEFITS	FEE-FOR-SERVICE PLAN	HEALTH PLAN OF NEVADA HMO	HOMETOWN HEALTH HMO
REGIONS AVAILABLE	***ALL STATES***	***NV ONLY*** *(and parts of CA&AZ)*	***NO. NV ONLY***
	(What the Plan Pays)	*(Your Cost)*	*(Your Cost)*
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 after deductible is satisfied; limited to 20 visits per calendar year	$30 per visit; limited to 20 visits per calendar year
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 after deductible is satisfied; limited to 30 days per calendar year	$250 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	$50 per visit after deductible is satisfied

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DESCRIPTION OF BENEFITS	FEE-FOR-SERVICE PLAN	HEALTH PLAN OF NEVADA HMO	HOMETOWN HEALTH HMO
REGIONS AVAILABLE	***ALL STATES***	***NV ONLY*** ***(and parts of CA&AZ)***	***NO. NV ONLY***
	(What the Plan Pays)	*(Your Cost)*	*(Your Cost)*
Nervous & Mental Condition			
In-Patient Hospital *(As defined by AB88, Health & Safety Code 1374.72)	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 (40 days for severe mental illness)	$400 per admission after deductible is satisfied; limited to 40 days per calendar year
Out-Patient Physician Only	By a **contracting** provider 80% of allowable charges, By a **non-contracting provider**, 55% of allowable charges, 60 visit limit per year (no benefits for out-patient facility charges)	$30 per visit after deductible is satisfied; limited to 20 visits per calendar year (no visit limits for severe mental illness)	$50 per visit after deductible is satisfied; limited to 40 visits per calendar year
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)

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PRESCRIPTION DRUGS

(no annual deductible)

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

DESCRIPTION OF BENEFITS	FEE-FOR-SERVICE PLAN	HEALTH PLAN OF NEVADA	HOMETOWN HEALTH
REGIONS AVAILABLE	***ALL STATES***	***NV ONLY** (and parts of CA&AZ)*	***NO. NV ONLY***
	(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		You pay the lower of the cost of the drug or the co-pay
Generic	$10	$10	$10
Formulary Brand	$30*	$30	$30*
Non-Formulary	$50*	$50*	$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
MAIL (90 day supply)			
Generic	$25	$20	$20
Formulary Brand	$75*	$60	$60*
Non-Formulary	$125*	Not covered	$100*
**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)	Not covered except in case of emergency or urgent care. Pay full price and submit receipt for reimbursement, less co-pay	Reimbursed at 90% of contracted rates as if purchased at a participating pharmacy, (After a $50 co-payment per prescription)

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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 covered expenses incurred during the remainder of that year for that person.

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 Note: The above HMO Plan benefits show only a partial summary of benefits. Please refer to the HMO 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 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 HMO Evidence of Coverage document for details. You may also visit us on-line at www.carpenterssw.org.

(Rev. 11/9/10 kh)