

**SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST
COMPARISON OF MEDICAL AND PRESCRIPTION PLANS
FOR ALL RETIRED PARTICIPANTS**

| DESCRIPTION OF BENEFITS | FEE-FOR-SERVICE PLAN | KAISER | AETNA HMO | BLUE CROSS AND BLUE SHIELD OF NM EPO | HEALTH PLAN OF NEVADA HMO | HOMETOWN HEALTH HMO | SELECT HEALTH HMO |
|-------------------------------------|--|--|-------------------------------------|---|---|---|---|
| REGIONS AVAILABLE | ALL STATES | CA ONLY | CA AND AZ ONLY | NM ONLY <i>(and parts of CO&TX)</i> | NV ONLY <i>(and parts of CA & AZ)</i> | NO. NV ONLY | UT ONLY |
| | <i>(What the Plan Pays)</i> | <i>(Your Cost)</i> | <i>(Your Cost)</i> | <i>(Your Cost)</i> | <i>(Your Cost)</i> | <i>(Your Cost)</i> | <i>(Your Cost)</i> |
| MEDICAL BENEFITS | | | | | | | |
| CALENDAR YEAR DEDUCTIBLE | \$350 per person | None | None | None | None | None | None |
| LIFETIME MAXIMUM | \$250,000 per person | None | None | None | None | None | \$2,500,000 |
| HOSPITAL | <i>See directory</i> | <i>See directory</i> | <i>See directory</i> | <i>See directory</i> | <i>See directory</i> | <i>See directory</i> | <i>See directory</i> |
| In-patient | Contracting facility, 80% of allowable charges Non-contracting facility, 60% of allowable charges | None | None | None | \$150 per admission | \$100 per admission | None |
| Out-patient Surgery | Contracting facility, 80% of allowable charges Non-Contracting facility, 60% (Maximum allowable \$5,000 per operative session) | \$10 per visit or procedure effective 9/1/08 | None | None | \$50 per admission | \$50 per admission | None |
| Out-patient Emergency Care | \$50 per visit (waived if admitted), then... Contracting facility, 80% of allowable charges Non-contracting facility, 60% of allowable charges (maximum allowable \$3,500) | \$50 per visit (waived if admitted) | \$50 per visit (waived if admitted) | \$50 per visit (waived if admitted) | Within service area \$50 per visit, waived if admitted; outside service area \$75, waived if admitted | \$75 for emergency care (all areas) | Emergency room \$50 for participating facilities, \$100 for non-participating facilities (waived if admitted) |
| Other Hospital Out-patient Services | Contracting facility, 80% Non-contracting facility, 60%, (maximum allowable \$3,500) | \$10 per visit or procedure effective 9/1/08 | None | None | Surgical assistant services –none; Anesthesia \$50 per surgery | Surgical assistant services – none Anesthesia – none | None |

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| 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 | None | None | \$50 per trip | \$100 per trip | None |
| Extended Care Facility | 80%, 180 day limit per disability | None; 100 day limit per benefit period | None | None: Prior authorization is required | \$150 per admission limited to 100 days per calendar year | \$100 per admission limited to 100 days per calendar year | None, limited to 60 days per calendar year |
| Routine Physical Examination | | | | | | | |
| Retiree & Spouse | 80% of allowable charges up to a maximum payment of \$500 per person per year for exam, laboratory and x-ray | \$10 effective 9/1/08 | \$10 | \$10 for primary care physician \$20 for specialist | \$10 | \$10 for primary care physician \$20 for specialist | \$10 for primary care physician \$20 for specialist |
| Physician | | | | | | | |
| Surgery – In-Patient | If performed by a contracting physician, 80% of allowable charges By a non-contracting physician, 60% of allowable charges | None | None | None | \$25 per surgery | None | None |
| Surgery – Out-Patient | If performed by a contracting physician, 80% of allowable charges By a non-contracting physician, 60% of allowable charges | \$10 effective 9/1/08 | None | None | \$10 per surgery | \$10 per visit for primary care physician \$20 per visit for specialist | None |

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| Hospital, Office & Home Visits | If rendered by a contracting physician, 80% of allowable charges By a non-contracting physician, 60% of allowable charges | None for hospital and home visit \$10 for out-patient office visit effective 9/1/08 | None for hospital and home visit \$10 for non-specialist office visit \$20 for specialist | None for hospital and home visits; \$10 for non-specialist office visit \$20 for specialist | None for in-patient visit \$10 for non-specialist office visit \$20 for home visit | None for in-patient visit, \$10 per office and home visit \$20 for specialist | None for hospital visits \$10 for non-specialist office visit \$20 for specialists office visit; Home visits not covered |
| Second Surgical Opinion | 100% up to \$150 (contracting or non-contracting provider) | \$10 (within Kaiser) effective 9/1/08 | \$20 | \$20 | \$20 for specialist | \$20 | Office visit applies |
| Diagnostic X-ray & Laboratory | If performed by a contracting provider, 80% of allowable charges By a non-contracting provider, 60% of allowable charges | None | \$10 if performed in PCP's office \$20 if performed in specialist's office | None | \$10 routine out-patient radiology or lab per visit; \$20 complex diagnostic, per visit or procedure; \$250 for PET scan | None for routine out-patient radiology & lab, \$50 for CT scans, \$75 for MRI and PET scans | None |
| Maternity (Female Retiree or Spouse) | Same as any illness | Same as any illness | \$20 for initial visit | \$10 initial visit, then no cost | Same as any illness | Same as any illness | None |

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| Durable Medical Equipment and Corrective Appliances | If supplied by a contracting provider, 80% of allowable charges By a non-contracting provider, 60% of allowable charges | Covered on a limited basis | None | None; prior authorization required | DME \$100 or 50% of eligible medical expense of rental or purchase price; Prosthetic and orthotic devices are \$750 per device, maximum \$10,000 lifetime | DME – None; Prosthetic and orthotic devices are \$25 per device | None, must preauthorize purchases greater than \$750 |
| Home Health Care/ Nursing Care (at home) | By a contracting provider, 80% of allowable charges. By a non-contracting provider 60% (maximum allowable charge is \$120 per visit for a registered nurse and \$60 per visit for a LPN or LVN) | None | None | None; some services require prior authorization, 100 visit limit per year | \$20 per visit for physician house calls and home care services; No charge for private duty nurse | \$10 per visit | None |
| Chiropractor | \$10 benefit per visit, 24 visit limit per year | Not Covered | \$15 per visit, limited to 30 visits per calendar year | \$10 for primary care physician \$20 for specialist | \$20 per visit | \$20 per visit, limited to \$1,000 per calendar year | \$10 per visit, 15 visits per year (excluded from out of pocket maximum; Must use ASHN providers) |

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| Physical Therapy (short-term out-patient) | By a contracting provider, 80% of allowable charges By a non-contracting provider, 60% (maximum allowable charge is \$60 per visit) Limit of 20 visits per calendar year | \$10 per visit effective 9/1/08 | \$20 per visit; 60 day limitation per incident or illness | \$10 for primary care physician \$20 for specialist | \$10 co-pay per visit, maximum benefit of 60 days/visits per member per calendar year | \$20 per visit, limited to 20 visits per calendar year | \$20 per visit, up to 20 visits per year |
| Speech Therapy (short-term out-patient) | Not covered | \$10 per visit effective 9/1/08 | \$20 per visit; 60 day limitation per incident or illness | \$10 for primary care physician \$20 for specialist | \$10 co-pay per visit, maximum benefit of 60 days/visits per member per calendar year | \$20 per visit, limited to 20 sessions per calendar year | \$20per visit, up to 20 visits per year |
| Alcoholism & Drug | | | | | | | |
| In-Patient | Not covered | No Charge for medical management of withdrawal symptoms & recovery services | None; up to 30 day limitation for rehabilitation | None | \$150 per admission, limited to \$9,000 per member, per calendar year | \$100 per admission, limited to \$9000 per member, per calendar year | 50%, \$1,000 single out of pocket maximum, \$2,000 family for mental health services (in-patient, out-patient and office visits) |
| Out-Patient | Not covered | \$10 for counseling & medical management of withdrawal symptoms (\$5 for group therapy) | \$20 per visit, 20 visit limit per year | \$10 for primary care physician \$20 for specialist Prior authorization required | \$10 per visit | \$20 per visit limited to \$2,500 per calendar year for out-patient treatment; \$1,500 per calendar year for withdrawal treatment | 50%, \$1,000 single out of pocket maximum, \$2,000 family for mental health services (in-patient, out-patient and office visits) |

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| Nervous & Mental Conditions | | | | | | | |
| 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 (partial confinement not covered) | *First 45 days at No Charge (AB88), other hospital alternative services available | Covered same as any other illness; 30 day limitation for non-serious illness (serious or non-serious in AZ) | None | \$150 per admission, limited to 40 days per member per year | \$100 per admission, limited to 40 days of hospitalization per year | See alcoholism and drug addiction. Combined benefit of mental and chemical dependency |
| Out-Patient Physician Only | Not covered | * \$10 per visit for 20 visits per calendar year for non- AB88 conditions \$10 for 21 + visits for AB88 conditions | \$20 per visit; 20 visit limitation for non-serious illness (serious or non-serious for AZ) | \$10 for primary care physician \$20 for specialist Prior authorization required | \$10 per session, limited to 40 visits per calendar year | \$20 per session | See alcoholism and drug addiction. Combined benefit of mental and chemical dependency |
| Other Covered Services and Supplies | By a contracting provider, 80% of allowable charges By a non-contracting provider, 60% of allowable charges | Varying co-pays may apply | Varying co-pays may apply | Varying co-pays may apply | Varying co-pays may apply | Varying co-pays may apply | None |

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| PRESCRIPTION DRUGS (no annual deductible) | | | | | | | |
| When Obtained at Participating Pharmacy (all plans have mandatory generic substitution and formulary management programs) | | | | | | | |
| RETAIL (30 day supply) | (using Medco Card) | | | | | (using Medco Card) | |
| Generic | \$10 | \$10 | \$10 | \$10 | \$7 | \$10 | \$10 |
| Formulary Brand | \$30* | \$20 | \$20* | \$20 | \$30 | \$30* | \$25* |
| Non-Formulary | \$50* | Not covered unless medically necessary | Not covered unless medically necessary | Not covered | \$50* | \$50* | \$45* |
| | 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 | |
| MAIL (90 day supply) | | | | | | | |
| Generic | \$20 | \$20 (100 day supply) | \$20 | \$20 | \$14 | \$20 | \$10 |
| Formulary Brand | \$60* | \$40 (100 day supply) | \$40* | \$40 | \$60 | \$60* | \$50 |
| Non-Formulary | \$100* | Not covered unless medically necessary | Not covered unless medically necessary | Not covered | Not covered | \$100* | \$135 |
| <i>*If a generic is available, and you or your doctor indicate "Do not substitute" on the Rx, you will be charged the brand co-payment, plus the difference in cost between the generic and the brand named drug.</i> | | | | | | | Rx co-pays are excluded from out of pocket maximums |
| When Obtained at a Non-Participating Pharmacy | Reimbursed at 80% of contracted rates as if purchased at a participating pharmacy, (After a \$50 co-payment per prescription) | Not covered except in case of emergency | Not covered except in case of emergency or urgent care | Not covered except in case of emergency | Not covered except in case of emergency or urgent care | Reimbursed at 80% of contracted rates as if purchased at a participating pharmacy, (After a \$50 co-payment per prescription) | Pay full price, submit receipt for reimbursement for covered drugs |

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IMPORTANT: *All new or reinstated retirees must enroll in an HMO/EPO plan unless they reside outside an HMO/EPO service area.*

FFS Networks: For a listing of participating Fee-For-Service medical providers in California visit www.bluecrossca.com. For services rendered in Nevada, the provider network is Anthem Blue Cross Blue Shield at www.anthem.com. For services rendered in New Mexico, the FFS benefit is managed by Blue Shield of California using the Blue Cross and Blue Shield of New Mexico network. For services rendered outside California, Nevada and New Mexico the provider network is First Health at www.firsthealth.com.

FFS Notes: When the total of certain out-of-pocket allowable charges incurred by a Fee-for-Service member reaches \$10,000 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 preauthorized within 48 hours.

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.