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

2016

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.

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST **Visit us at www.carpenterssw.org**
COMPARISON OF MEDICAL AND PRESCRIPTION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2016

IMPORTANT: All new or reinstated eligibles can not enroll in Fee-For-Service PPO Plan until the Trust's next scheduled open enrollment period unless they live outside an HMO/EPO service area.

Fee-for Service PPO Plan Notes: Only "allowable charges" are used in determining benefits under the Fee-for-Service PPO Plan. The term "allowable charges" has a specific meaning under the Fee-For-Service PPO 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 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 above 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 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, EPO or PPO Plan. All charges associated with non-covered services or denied claims will be the member's responsibility.

We encourage you to visit us on-line 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.

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BENEFITS	FEE-FOR-SERVICE PPO PLAN	KAISER		UNITEDHEALTHCARE			HEALTH PLAN OF NEVADA HMO Plan	ANTHEM BLUE CROSS & BLUE SHIELD HMO Plan	SELECT HEALTH HMO Plan
		HMO Plan	HMO Plan	HMO Plan	Choice Plus PPO Plan	Choice EPO Plan			
REGIONS AVAILABLE	***ALL STATES***	***CA ONLY***	***CO ONLY***	***CA ONLY***	***AZ & NM (and parts of TX)***	***CO & WY***	***NV ONLY (and parts of AZ)***	***NORTHERN NV ONLY***	***UT ONLY***
Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Calendar Year Deductible – the deductible applies to all medical benefits unless otherwise stated	PPO or non-PPO - $500 per person, maximum of $1,500 per family	None	None	$100 per person, maximum of $200 per family	PPO - $100 per person, maximum of $200 per family Non-PPO - $2,000 per person, maximum of $4,000 per family	$100 per person, maximum of $200 per family	None	None	$100 per person, maximum of $200 per family
Calendar Year Out-of-Pocket Maximum (includes deductibles and most copays & coinsurance)	PPO - $5,600 per person, $11,200 per family Non-PPO – No maximum (except for emergency care)	$1,500 per person, $3,000 per family	$2,000 per person, $4,000 per family	$1,000 per person, $3,000 per family	PPO - $1,000 per person, $2,000 per family Non-PPO - $5,000 per person, $10,000 per family	$1,000 per person, $2,000 per family	$6,250 per person, $12,500 per family	$6,000 per person, $12,000 per family	$2,000 per person, $4,000 per family

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Hospital									
Inpatient	PPO – 20% Non-PPO – 50%	$500 per admission	10%	$500 per admission	PPO - $500 per admission Non-PPO – 50%	$500 per admission plus 10%	$300 per day, $900 maximum per admission	$500 per day, $2,000 maximum per admission	$500 per admission plus 10%
Outpatient surgery	PPO- 20% Non-PPO – 50% ($5,000 maximum allowable per session)	$40 per visit or procedure ($20 for non-specialist)	10%	$40 per visit or procedure ($20 for non-specialist)	PPO - $40 per visit or procedure ($20 for non-specialist) Non-PPO - 50%	$40 per visit or procedure ($20 for non-specialist)	$300 per surgery ($150 for anesthesia)	$400 per surgery	10%
Emergency room	$250 per visit (waived if admitted), then: PPO – 20% Non-PPO - 20% (50% if not true emergency)	$150 per visit (waived if admitted)	$100 per visit (waived if admitted); specialty procedures charged separately	$250 per visit (waived if admitted) – deductible does not apply	PPO or non-PPO - $250 per visit – deductible does not apply	$250 per visit (waived if admitted) – deductible does not apply	$250 per visit (waived if admitted)	$300 per visit (waived if admitted)	$250 per visit

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Ambulance Services	PPO – 20% Non-PPO – 50% (maximum allowable $1,075 per trip for ground, $19,000 per trip for air)	$50 per trip	$150 per trip	$50 per trip	PPO - None in AZ; $50 per trip (no deductible) in NM & TX Non-PPO - $50 per trip (no deductible)	10%	$250 per trip	$300 per ground or air trip	$50 per trip for ground, $100 per trip for air
Extended Care Facility	PPO or Non-PPO - none for first 30 days, 20% thereafter for room and board and 20% for other services, 180 day limit per disability	None; 100 day limit per benefit period	10%; 100 day limit per calendar year	10%; limited to 100 consecutive calendar days from the first treatment per disability – deductible does not apply	PPO - None Non-PPO - 50% limited to 60 days per calendar year	10%; 100 day limit per calendar year	$400 per admission, waived if admitted from an acute care facility; limited to 100 days per calendar year (skilled Nursing Facility only)	$500 per day, $2,000 maximum per admission; limited to 30 days per calendar year (100 days for skilled nursing facility; copay waived if admitted directly from an acute care facility)	$500 per admission then 10%; limited to 100 days per calendar year

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*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	PPO – None, deductible does not apply Non-PPO 50%	None for primary care physician, specialist and well baby/prenatal care	None	None for primary care physician, specialist and well baby/prenatal care – deductible does not apply	PPO – None, deductible does not apply Non-PPO – no coverage	None	None	None	None
Physical Exam, Screenings, Laboratory and Other Tests & Immunizations	PPO – None, deductible does not apply Non-PPO 50%	None	None	None	PPO – None, deductible does not apply Non-PPO – no coverage	None	None	None	None

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Physician									
Surgery – In-Patient	PPO – 20% Non-PPO – 50%	None after per admission hospital co-pay is satisfied	10%	None after per admission hospital co-pays are satisfied	PPO – None after hospital co-pay is satisfied in AZ; 10% after hospital copay is satisfied in NM & TX Non-PPO – 50%	None after per admission hospital co-pays are satisfied	$150 per surgery	None	10% after hospital inpatient co-pays are satisfied
Surgery – Out-Patient	PPO – 20% Non-PPO – 50%	$40 per visit ($20 for non-specialist)	10%	$40 per visit ($20 for non-specialist)	PPO - None in AZ; 10% in NM & TX Non-PPO - 50%	$40 per visit ($20 for non-specialist)	$150 per surgery	$400 per surgery	10%
Hospital Visits	PPO – 20% Non-PPO – 50%	None	10%	None	PPO – None in AZ; 10% in NM & TX Non-PPO – 50%	None	None	None	10%

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Office Visits	PPO – 20% Non-PPO – 50%	$20 for non-specialist visit; $40 for specialist	$20 for non-specialist visit; $30 for specialist; plus 10% for procedures performed	$20 for non-specialist visit; $40 for specialist – deductible does not apply	PPO - $20 for non-specialist visit; $40 for specialist – deductible does not apply Non-PPO – 50%	$20 for non-specialist visit; $40 for specialist – deductible does not apply	$25 for non-specialist visit; $50 for specialist	$30 for non-specialist visit; $60 for specialist	$20 for non-specialist visit; $40 for specialist
Second Surgical Opinion from a Specialist	PPO or non-PPO – None up to $150 – deductible does not apply	$40 per visit (within Kaiser)	$30 per visit (within Kaiser)	$40 per visit	PPO - $40 per visit – deductible does not apply Non-PPO – 50%	$40 per visit – deductible does not apply	$50 per visit	$60 per visit	$40 per visit

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Maternity	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit at 100% if PPO); there is NO maternity coverage for children	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no co-pay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no co-pay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no co-pay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no co-pay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no co-pay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no co-pay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no co-pay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no co-pay)
Diagnostic X-ray & Lab (outpatient)	PPO – 20% Non-PPO – 50%	None	10%; none for laboratory at Kaiser facilities	None for routine tests; $100 per procedure for complex tests such as CAT scans, MRIs and PET scans	PPO – None in AZ; 10% in NM & TX Non-PPO – 50%	None for routine tests; 10% for complex tests such as CAT scans, MRIs and PET scans	$25 per visit X-ray, $15 for lab	$30 for non-specialist, $60 for specialist for routine tests; $100 per procedure for complex tests - CAT scans, MRIs & MRAs; $750 for PET scans	None for routine/minor tests; $100 per procedure for complex tests such as CAT scans, MRIs and PET scans

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Durable Medical Equipment and Corrective Appliances	PPO – 20% Non-PPO – 50%	None; some items are subject to a $2,000 calendar year maximum	10%	10%; some items are subject to a $5,000 calendar year maximum	PPO – 10% Non-PPO – 50% Some items are subject to a $2,500 calendar year maximum in AZ; frequency limits apply	10%; some items are subject to a $2,500 calendar year maximum and frequency limits	Durable medical equipment – none, frequency limits apply; corrective appliances - $750 per device, frequency limits apply	None	10%
Hearing Aids	Not covered	None; subject to a $1,000 maximum benefit per device, one device per ear and 2 devices every 36 months	None; subject to a $1,000 maximum benefit per device, one device per ear and 2 devices every 36 months	None; subject to a $5,000 calendar year maximum and frequency limits	PPO – None in AZ; 10% in NM & TX Non-PPO – 50% PPO & Non-PPO subject to a $2,500 calendar year maximum and frequency limits	10%; subject to a $2,500 calendar year maximum and frequency limits	None; subject to frequency limits	None; subject to frequency limits	None; subject to a $1,000 maximum per device and frequency limits apply

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Home Health Care/ Nursing Care (at home)	PPO – 20% Non-PPO – 50%	None; limited to 100 visits per calendar year	10%	$20 per visit; limited to 100 visits per calendar year – deductible does not apply	PPO - $20 per visit, deductible does not apply Non-PPO - 50% Limited to 100 visits per calendar year PPO & Non-PPO	10%; limited to 100 visits per calendar year	$35 per visit	$60 per visit	$20 per visit
Chiropractor	PPO or Non-PPO all charges in excess of $10 benefit per visit, limited to 24 visits per calendar year	$15 per visit; limited to 20 visits per calendar year	$20 per visit; limited to 20 visits per calendar year	$40 per visit; limited to 20 visits per calendar year	PPO - $40 per visit, deductible does not apply Non-PPO - 50% Limited to 20 visits per calendar year PPO & Non-PPO	$40 per visit; limited to 20 visits per calendar year – deductible does not apply	$25 per visit; limited to 20 visits per calendar year	$30 per visit; limited to 12 visits per calendar year	$30 per visit; limited to 20 visits per calendar year – deductible does not apply

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Physical Therapy (short-term out-patient)	PPO – 20% Non-PPO – 50% Limited to 20 visits per calendar year PPO and non-PPO combined	$20 per visit	$20 per visit; limited to 20 visits per calendar year	$40 per visit	PPO - $40 per visit, deductible does not apply Non-PPO - 50% Limited to 20 visits per calendar year PPO & Non-PPO	$40 per visit; limited to 20 visits per calendar year – deductible does not apply	$25 per visit; limited to 120 days/visits per calendar year	$60 per visit; limited to 30 visits per calendar year for most therapy	$40 per visit; limited to 20 visits per calendar year
Speech Therapy (short-term out-patient)	PPO – 20% Non-PPO – 50% Limited to 130 visits per lifetime PPO & Non-PPO combined	$20 per visit	$20 per visit; limited to 20 visits per calendar year	$20 per visit	PPO - $40 per visit, deductible does not apply Non-PPO - 50% Limited to 20 visits per calendar year PPO & Non-PPO	$40 per visit; limited to 20 visits per calendar year – deductible does not apply	$25 per visit; limited to 120 days/visits per calendar year	$60 per visit; limited to 30 visits per calendar year for physical, occupational and speech therapy combined	$40 per visit; limited to 20 visits per calendar year

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Alcoholism & Drug Addiction									
In-Patient	PPO – 20% Non-PPO – 50%	$500 per admission ($100 for transitional residential care)	10%	$500 per admission	PPO - $500 per admission Non-PPO - 50%	10%	$300 per day; $900 maximum per admission	$500 per day, $2,000 maximum per admission	$500 per admission then 10%
Out-Patient	PPO – 20% Non-PPO – 50%	$20 per visit ($5 for group session)	$20 per visit plus 10% for procedures performed during the visit	$40 per visit	PPO - $40 per visit, deductible does not apply Non-PPO - 50%	$40 per visit – deductible does not apply	$25 per visit	$30 per visit; none for outpatient facility	$20 per office visit – deductible does not apply; 10% other out-patient
Mental Health									
In-Patient Hospital	PPO – 20% Non-PPO – 50%	$500 per admission	10%	$500 per admission	PPO - $500 per admission Non-PPO - 50%	10%	$300 per day; $900 maximum per admission	$500 per day; $2,000 maximum per admission	$500 per admission then 10%

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Medical Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Out-Patient	PPO – 20% Non-PPO – 50%	$20 per visit ($10 for group session)	$20 per visit plus 10% for procedures performed during the visit	$40 per visit – deductible does not apply	PPO - $40 per visit, deductible does not apply Non-PPO - 50%	$40 per visit – deductible does not apply	$25 per visit	$30 per visit; none for outpatient facility	$20 per office visit – deductible does not apply; 10% other out-patient
Other Covered Services and Supplies	PPO – 20% Non-PPO – 50%	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	Varying co-pays may apply	Varying co-pays may apply	Varying co-pays may apply

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Prescription Drug Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Calendar Year Deductible	None	None	None	None	None	None	None	None	None
Calendar Year Out-of-Pocket Maximum (includes deductibles, copays & coinsurance)	Network pharmacy or mail service - $1,000 per person, $2,000 per family Non-Network pharmacy – No maximum	Medical Benefits Out-of-Pocket Maximum is a combined maximum for medical & prescription drug benefits	Medical Benefits Out-of-Pocket Maximum is a combined maximum for medical & prescription drug benefits	Medical Benefits Out-of-Pocket Maximum is a combined maximum for medical & prescription drug benefits	Medical Benefits Out-of-Pocket Maximum is a combined maximum for medical & prescription drug benefits	Medical Benefits Out-of-Pocket Maximum is a combined maximum for medical & prescription drug benefits	Medical Benefits Out-of-Pocket Maximum is a combined maximum for medical & prescription drug benefits	Medical Benefits Out-of-Pocket Maximum is a combined maximum for medical & prescription drug benefits	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 co-pay								
Generic	$10; $0 for prescription contraceptives	$10; $0 for prescription contraceptives	$10; $0 for prescription contraceptives	$10; $0 for prescription contraceptives	$10; $0 for prescription contraceptives	$10; $0 for prescription contraceptives	Tier 1: $10; $0 for prescription contraceptives	Tier 1: $15; $0 for prescription contraceptives	Tier 1: $10; $0 for prescription contraceptives

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST **Visit us at www.carpenterssw.org**

COMPARISON OF MEDICAL AND PRESCRIPTION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2016

BENEFITS	FEE-FOR-SERVICE PPO PLAN	KAISER		UNITEDHEALTHCARE			HEALTH PLAN OF NEVADA HMO Plan	ANTHEM BLUE CROSS & BLUE SHIELD HMO Plan	SELECT HEALTH HMO Plan
		HMO Plan	HMO Plan	HMO Plan	Choice Plus PPO Plan	Choice EPO Plan			
REGIONS AVAILABLE	***ALL STATES***	***CA ONLY***	***CO ONLY***	***CA ONLY***	***AZ & NM (and parts of TX)***	***CO & WY***	***NV ONLY (and parts of AZ)***	***NORTHERN NV ONLY***	***UT ONLY***
Prescription Drug Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Formulary Brand	$40*	$35	$30	$35*	$35	$35*	Tier 2: $35	Tier 2: $30*	Tier 2: $35*
Non-Formulary	$60*	Not covered unless medically necessary	$50	Not covered unless medically necessary	$35	$35*	Tier 3: $60*	Tier 3: 20%, up to $200 per 30 day supply* non-formulary drugs are not covered	Tier 3: $60* Tier 4: $100*
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	No limit	No limit	No limit	No limit	No limit	No limit	No limit

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FOR ACTIVE PARTICIPANTS AS OF JANUARY 1, 2016

BENEFITS	FEE-FOR-SERVICE PPO PLAN	KAISER		UNITEDHEALTHCARE			HEALTH PLAN OF NEVADA HMO Plan	ANTHEM BLUE CROSS & BLUE SHIELD HMO Plan	SELECT HEALTH HMO Plan
		HMO Plan	HMO Plan	HMO Plan	Choice Plus PPO Plan	Choice EPO Plan			
REGIONS AVAILABLE	***ALL STATES***	***CA ONLY***	***CO ONLY***	***CA ONLY***	***AZ & NM (and parts of TX)***	***CO & WY***	***NV ONLY (and parts of AZ)***	***NORTHERN NV ONLY***	***UT ONLY***
Prescription Drug Benefits	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*	*Your Cost*
Mail (90 day supply)		100 day supply	100 day supply						
Generic	$25; $0 for prescription contraceptives	$20; $0 for prescription contraceptives	$20; $0 for prescription contraceptives	$20; $0 for prescription contraceptives	$20; $0 for prescription contraceptives	$20; $0 for prescription contraceptives	Tier 1: $25; $0 for prescription contraceptives	Tier 1: $15; $0 for prescription contraceptives	Tier 1: $20; $0 for prescription contraceptives
Formulary Brand	$100	$70	$60	$70*	$70	$70*	Tier 2: $87.50	Tier 2: $60	Tier 2: $70
Non-Formulary	$150	Not covered unless medically necessary	$100	Not covered unless medically necessary	$70	$70*	Tier 3: $150	Not covered	Tier 3: $180

*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.