Active

2025 Health Plan Benefits "At a Glance"

As of June 1, 2025

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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 carpenterssw.org.

Medical PPO Plan Notes: Only “allowable charges” are used in determining benefits under the 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 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.

WESTERN STATES CARPENTERS HEALTH AND WELFARE PLAN
COMPARISON OF MEDICAL BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JUNE 1, 2025

Visit us at carpenterssw.org

MEDICAL BENEFITS	**WESTERN STATES CARPENTERS**			
	PPO COPAY PLAN		**BRONZE PLAN**	
REGIONS AVAILABLE	***ALL STATES***		***AZ, NM, CO, UT, NV, CA, WA, OR, ID, MT***	
	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
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
Hospital				
Inpatient	$500 per admission	50%	20%	50%
Outpatient surgery	$250 per surgery	50% ($5,000 max allowable per session)	20%	50% ($5,000 max allowable per session)
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)
Urgent Care	$50 per visit	50%	20%	20%
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
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	
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%
Physical Exam, Screenings, Laboratory and Other Tests & Immunizations	None	50%	None, deductible does not apply	50%
Physician				
Surgery – Inpatient	None for non-specialist, $30 for specialist	50%	20%	50%
Surgery – Outpatient	None for non-specialist, $30 for specialist	50% ($3,500 max allowable per session)	20%	50% ($3,500 max allowable per session)
Hospital Visits	None for non-specialist, $30 for specialist	50%	20%	50%
Office Visits	$15 for non-specialist, $30 for specialist	50%	20%	50%

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MEDICAL BENEFITS	WESTERN STATES CARPENTERS			
	PPO COPAY PLAN		BRONZE PLAN	
REGIONS AVAILABLE	*ALL STATES*		*AZ, NM, CO, UT, NV, CA, WA, OR, ID, MT*	
	Your Cost		*Your Cost*	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Second Surgical Opinion from a Specialist	$30 per visit	50%	None up to $150, deductible does not apply	50%
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	
Diagnostic X-ray, Lab (Outpatient), MRI, CT, and PET scans	$30 per visit	50%	20%	50%
Durable Medical Equipment and Corrective Appliances	$30 per item	50%	20%	50%
Hearing Aids	$30; 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	
Home Health Care/Nursing Care (at home)	$30 per visit	50%	20%	50%
Chiropractor	$15 per visit	50%	All charges in excess of $10 benefit per visit, limited to 24 visits per year	
	In- & Out-of-Network limited to 24 visits per year			
Physical Therapy (short-term outpatient)	$15 per visit	50%	20%	50%
	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%
	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%
Outpatient	$15 per visit	50%	20%	50%
Mental Health				
Inpatient Hospital	$500 per visit	50%	20%	50%
Outpatient	$15 per visit	50%	20%	50%
Other Covered Services and Supplies	Varying cost share may apply	50%	20%	50%

MEDICAL BENEFITS	KAISER			
	HEALTH PLAN			
REGIONS AVAILABLE	*CA*	*CO*	*NW*	*WA*
	Your Cost	*Your Cost*	*Your Cost*	*Your Cost*
Calendar Year Deductible – the deductible applies to all medical benefits unless otherwise stated (Self-Only / Family Max)	$250 / $500	$250 / $500	$250 / $500	$250 / $500
Calendar Year Out-of-Pocket Maximum (includes deductibles and most copays & coinsurance) (Self-Only / Family)	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000
Hospital				
Inpatient	20%	20%	20%	20%
Outpatient surgery	20%	$500 in a Plan Ambulatory Surgery Center (ASC)	20%	20%
Emergency room (copay waived if admitted)	20%	20%	20%	20%
Urgent Care	$20 per visit, deductible does not apply	$20 per visit	$20 per visit, deductible does not apply	$20 per visit, deductible does not apply
Ambulance Services	$150 per trip	$150 per trip, deductible does not apply	$150 per trip, deductible does not apply	$150 per trip
Extended Care Facility	20%; limited to 100 days per benefit period	20%; limited to 100 days per benefit period	20%; limited to 100 days per benefit period	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 for primary care physician, specialist and well-baby/prenatal care, deductible does not apply	None for primary care physician, specialist and well-baby/prenatal care, deductible does not apply	None for primary care physician, specialist and well-baby/prenatal care, deductible does not apply	None for primary care physician, specialist and well-baby/prenatal care, deductible does not apply
Physical Exam, Screenings, Laboratory and Other Tests & Immunizations	None, deductible does not apply	None, deductible does not apply	None, deductible does not apply	None, deductible does not apply
Physician				
Surgery – Inpatient	20%	20%	20%	20%
Surgery – Outpatient	20%	$500 in a Plan Ambulatory Surgery Center (ASC)	20%	20%
Hospital Visits	20%	20%	20%	20%
Office Visits	$20 for non-specialist, $30 for specialist, deductible does not apply	$20 for non-specialist, $30 for specialist, deductible does not apply	$20 for non-specialist, $30 for specialist, deductible does not apply	$20 for non-specialist, $30 for specialist, deductible does not apply
Second Surgical Opinion from a Specialist	$30 per visit (within Kaiser), deductible does not apply	$30 per visit (within Kaiser), deductible does not apply	$30 per visit (within Kaiser), deductible does not apply	$30 per visit (within Kaiser), deductible does not apply

MEDICAL BENEFITS	KAISER			
	HEALTH PLAN			
REGIONS AVAILABLE	*CA*	*CO*	*NW*	*WA*
	Your Cost	*Your Cost*	*Your Cost*	*Your Cost*
Maternity	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)	Same as any illness (certain pregnancy-related services are covered under Preventive Services benefit with no copay)
Diagnostic X-ray & Lab (Outpatient)	$10 per encounter	X-ray and lab in medical office - No charge, deductible does not apply Lab in hospital: 20%	$10 per encounter, deductible does not apply	$10 per encounter, deductible does not apply
MRI, CT, and PET scans	20% up to a maximum of $50 per procedure	$50 per procedure, deductible does not apply	$50 per procedure, deductible does not apply	$50 per procedure, deductible does not apply
Durable Medical Equipment and Corrective Appliances	20%, deductible does not apply	20%	None, deductible does not apply	20%, deductible does not apply
Hearing Aids	None, deductible does not apply; subject to a $1,000 max benefit per device, 1 device per ear and 2 devices every 36 months	None, deductible does not apply; subject to a $1,000 max benefit per device, 1 device per ear and 2 devices every 36 months	None, deductible does not apply; $3,000 allowance per ear every 36 months	None, deductible does not apply; $3,000 allowance per ear every 36 months
Home Health Care/Nursing Care (at home)	None, deductible does not apply; limited to 100 visits per year	None, deductible does not apply; limited to 100 visits per year	None, deductible does not apply; limited to 130 visits per year	None, deductible does not apply; limited to 130 visits per year
Chiropractor	$15 per visit, deductible does not apply; limited to 20 visits per 12-month period	$20 per visit, deductible does not apply; limited to 20 visits per year	$20 per visit, deductible does not apply; limited to 12 visits per year	$20 per visit, deductible does not apply; limited to 10 visits per year
Physical Therapy (short-term outpatient)	$20 per visit	$20 per visit; limited to 20 visits per year per type of therapy	$20 per visit, deductible does not apply; limited to 20 visits per year per type of therapy	$20 per visit
Speech Therapy (short-term outpatient)	$20 per visit	$20 per visit, limited to 20 visits per year per type of therapy	$20 per visit, deductible does not apply; limited to 20 visits per year per type of therapy	$20 per visit

WESTERN STATES CARPENTERS HEALTH AND WELFARE PLAN
COMPARISON OF MEDICAL BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JUNE 1, 2025

MEDICAL BENEFITS	KAISER			
	HEALTH PLAN			
REGIONS AVAILABLE	***CA***	***CO***	***NW***	***WA***
	Your Cost	*Your Cost*	*Your Cost*	*Your Cost*
Alcoholism & Drug Addiction				
Inpatient	20%	20%	20%	20%
Outpatient	$20 per visit ($5 for group session), deductible does not apply	$20 per visit ($5 for group session), deductible does not apply	$20 per visit ($10 for group session), deductible does not apply	$20 per visit ($5 for group session), deductible does not apply
Mental Health				
Inpatient Hospital	20%	20%	20%	20%
Outpatient	$20 per visit ($10 for group session), deductible does not apply	$20 per visit ($10 for group session), deductible does not apply	$20 per visit ($10 for group session), deductible does not apply	$20 per visit ($10 for group session), deductible does not apply
Other Covered Services and Supplies	Varying cost share may apply	Varying cost share may apply	Varying cost share may apply	Varying cost share may apply

WESTERN STATES CARPENTERS HEALTH AND WELFARE PLAN
COMPARISON OF PRESCRIPTION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JUNE 1, 2025

Visit us at carpenterssw.org

PRESCRIPTION DRUG BENEFITS	WESTERN STATES CARPENTERS	KAISER
	PPO PLANS	HMO PLAN
REGIONS AVAILABLE	***PPO Copay Plan: ALL STATES*** ***Bronze Plan: AZ, NM, CO, UT, NV, CA, WA, OR, ID, MT***	***CA & CO & NW & WA***
	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, NW, WA: 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.

WESTERN STATES CARPENTERS HEALTH AND WELFARE PLAN
COMPARISON OF DENTAL BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JUNE 1, 2025

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DENTAL BENEFITS	**UNITEDHEALTHCARE**	
	DPPO PLAN	
REGIONS AVAILABLE	***ALL STATES***	
	Your Cost	
	In-Network*	Out-of-Network**
Calendar Year Deductible (Individual / Family); does not apply to Diagnostic & Preventive Services	$50 / $150	$50 / $150
Calendar Year Benefit Maximum Per Person	$3,000	$2,000
Orthodontic Lifetime Benefit Maximum	$2,000	
Diagnostic Services		
Periodic Oral Evaluation	$0	50%
Radiographs	$0	50%
Lab and Other Diagnostic Tests	$0	50%
Preventive Services		
Prophylaxis (Cleaning)	$0	50%
Fluoride Treatment (Preventive)	$0	50%
Sealants	$0	50%
Space Maintainers	$0	50%
Basic Services		
Restorations (Amalgams or Composite)	20%	50%
Emergency Treatment/General Services	20%	50%
Simple Extractions	20%	50%
Oral Surgery (incl. surgical extractions)	20%	50%
Periodontics	20%	50%
Endodontics	20%	50%
Major Services		
Inlays/Onlays/Crowns	20%	50%
Dentures and Removable Prosthetics	20%	50%
Fixed Partial Dentures (Bridges)	20%	50%
Orthodontic Services		
Diagnose or correct misalignment of the teeth or bite	20%	50%

* The network percentage of benefits is based on the discounted fees negotiated with the provider.

** The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

WESTERN STATES CARPENTERS HEALTH AND WELFARE PLAN
COMPARISON OF VISION BENEFITS
FOR ACTIVE PARTICIPANTS AS OF JUNE 1, 2025

VISION BENEFITS	VSP
	Vision Plan
REGIONS AVAILABLE	***ALL STATES***
	Your Cost
Exam	$0 copay
Prescription Glasses	Lenses Per Pair: $0 copay, Once Every 12 Months Frames: $150 allowance, Once Every 12 Months Lens Enhancements: Anti-reflective coating, polycarbonate, standard progressives, tints/dyes, and scratch-resistant coating are covered
Contact Lenses	Exam: up to $60 copay Elective contact lenses in lieu of lenses or frames: $150 allowance
Safety Glasses	Benefit includes coverage for a pair of safety glasses for the employee. Employee must be enrolled in the comprehensive plan to get the safety plan benefits. Lenses Per Pair: $0 copay, Once Every 12 Months Frames: Once every 24 Months. $60 frame allowance toward any safety frame from a VSP doctor, or covered in full safety frame from ProTec Eyewear® Collection, or covered in full safety frame from any Visionworks location Lens Enhancements: polycarbonate lenses are covered