California Ironworkers Field Welfare Plan 1/1/2014 Open Enrollment Benefit Plan Comparison – Effective 1/1/2014
Non-Medicare Retired Participants Residing in Arizona

Benefit Description For Non-Medicare Retirees	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Choice of Providers	If you live in Arizona, your network of hospitals and doctors is the National BlueCard network. Participants who use a Contract physician, hospital, or other provider will pay the least for services.	If you use a physician or other Provider who is not in the Contract Provider Network, you are using a Non-Contract (or Non-Contracting) Provider. Participants who use a Non-Contracting physician, hospital, or other provider; will pay more for services.
Calendar Year Deductible *The Fund's Calendar Year Deductible is never waived. However, some services are not subject to the Deductible.	Individual: $250* Family: $750* Does not apply to hearing exam, hearing aids, hospice, and prescription drugs.	Individual: $500* Family: $1,500* Does not apply to hearing exam, hearing aids, hospice, and prescription drugs. In addition, balance billing and excluded services do not count toward either deductible.
Lifetime Maximum	$1,000,000	$1,000,000
Annual Out-Of-Pocket Maximum	Individual: $2,000 Family: $6,000 Certain expenses do not count towards the Out-of-Pocket Maximum. For more information, see your Summary Plan Description.	None Your out-of-pocket expenses for services received at Non-Contract Providers are unlimited.
Contract Rate & Allowable Charges	Contract Rate: The amount that the Provider has agreed by contract to accept for the services provided.	Allowable Charges: For Non-Contract Providers, the Allowable Charge is the lesser of the charge billed by the Provider or the maximum amount the Board of Trustees has determined is an appropriate payment for the service(s) rendered. For Non-Contract Providers, the Plan generally pays 60% of the Allowable Charges. You are generally responsible for 40% of the Allowable Charges plus any charges over the Plan's Allowable Charge. NOTE: Providers' charges are often higher than the Plan's Allowable Charge. You are responsible for any charges above the Plan's Allowable Charge.
Pre-Authorization & Pre-Certification Requirements	Certain services and procedures require pre-authorization from Pacific Health Alliance ("PHA") or from Anthem. If you fail to obtain pre-authorization or pre-certification when it is required, the Plan's payment percentage will be reduced by 10%, and you will be responsible for an additional 10% coinsurance. Inpatient hospitalization (except for emergencies and childbirth) requires pre-certification by Anthem (800) 274-7767. Outpatient surgeries and procedures, and various other services, require pre-authorization from PHA (855) 754-7271.	

Benefit Description For Non-Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**
Description/Definition of Co-payment & Co-insurance	**Co-payments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service. **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service.	
Emergency Room and ER Physicians	80% of Contract Rate; **Deductible applies**	60% of Allowed Charges; **Deductible applies**
Emergency Ground Ambulance	80% of Contract Rate; **Deductible applies**	80% of Allowed Charges; **Deductible applies**
Urgent Care	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
Skilled Nursing Facility * Not subject to the Out-of-Pocket Maximum.	45% of Contract Rate up to 55 days per disability and admission must occur after a 5-day or more inpatient hospital stay; patient must be admitted to the SNF within 7-days of the hospital discharge **Deductible applies***	35% of Allowable Charges up to 55 days per disability and admission must occur after a 5-day or more inpatient hospital stay; patient must be admitted to the SNF within 7-days of the hospital discharge **Deductible applies***
Home Health Care	80% of Contract Rate; **Deductible applies**	60% of Allowed Charges; **Deductible applies**
Inpatient Hospital (including Physician Services) To Pre-Certify your hospital stay, call Anthem Blue Cross at (800) 274-7767	80% of Contract Rate **Deductible applies** Pre-certification by Anthem Blue Cross required.	60% of Allowable Charges **Deductible applies** Pre-certification by Anthem Blue Cross required.
Physician Office Visits	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**

Benefit Description For Non-Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**
Physician Home Visits	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
X-ray and Lab Services	80% of Contract Rate; **Deductible applies**	60% of Allowed Charges; **Deductible applies**
Podiatry Exam Orthotic Appliances	80% of Contract Rate; **Deductible applies** Not covered	60% of Allowable Charges; **Deductible applies** Not covered
Chiropractic and Acupuncture Services	80% of Contract Rate up to a maximum benefit of $2,000 per calendar year*; **Deductible applies** * The $2,000 maximum is a combined annual limit for all contract and non-contract chiropractic and acupuncture services.	60% of Allowable Charges up to a maximum benefit of $2,000 per calendar year*; **Deductible applies** * The $2,000 maximum is a combined annual limit for all contract and non-contract chiropractic and acupuncture services.
Outpatient Surgery (Facility Fee)	80% of Contract Rate; **Deductible applies** Pre-authorization required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.	Maximum benefit of $350 per day; **Deductible applies** You are responsible for any charges in excess of the Plan's maximum payment of $350 per day. Pre-authorization required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.
Physician/Surgeon Fee for Outpatient Surgery	80% of Contract Rate; **Deductible applies** Pre-authorization by PHA required.	60% of Allowable Charges; **Deductible applies** Pre-authorization by PHA required.
Complex Imaging (MRI, PET & CT scans)	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
Physical Therapy & Respiratory Therapy, Combined	80% of Contract Rate up to a maximum benefit of $2,000 per calendar year*; **Deductible applies** Pre-authorization by PHA required.	60% of Allowable Charges up to a maximum benefit of $2,000 per calendar year; **Deductible applies** Pre-authorization by PHA required.
Speech Therapy & Occupational Therapy, Combined	Only covered if the case manager determines that speech/occupational therapy is medically necessary.	Only covered if the case manager determines that speech/occupational therapy is medically necessary.

Benefit Description For Non-Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**
Medical Supplies, Orthopedic Braces, Prosthetic Appliances	80% of Contract Rate; **Deductible applies** Pre-authorization from PHA is required for equipment/supplies costing over $500.	60% of Allowable Charges; **Deductible applies** Pre-authorization from PHA is required for equipment/supplies costing over $500.
Chemotherapy/Radiation	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
Family Planning		
Infertility	Not covered	Not covered
Vasectomy (reversal is not covered)	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
Tubal Ligation (reversal is not covered)	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
Elective Abortions	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
Care for Allergies		
Office Visit	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
Testing	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
Treatment and Serum	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**
Immunizations	Covered under routine care and preventive healthcare	Covered under routine care and preventive healthcare
Hearing Care		
Exams	100% of Contract Rate up to a maximum benefit of $100 per calendar year*	100% of Allowed Charges up to a maximum benefit of $100 per calendar year*
Hearing Aids	100% of Contract Rate up to $2,000 per device limited to coverage every three years from the date of last purchase** *Charges applied to the $100 calendar year maximum are the combined total of PPO and Non-PPO charges for hearing exams **Charges applied to the $2,000 maximum are the combined total of PPO and Non-PPO charges for hearing aid devices. Your payments made towards allowable charges above the cap do not apply towards your out-of-pocket maximum.	100% of Allowed Charges up to $2,000 per device limited to coverage every three years from the date of last purchase** *Charges applied to the $100 calendar year maximum are the combined total of PPO and Non-PPO charges for hearing exams **Charges applied to the $2,000 maximum are the combined total of PPO and Non-PPO charges for hearing aid devices

Benefit Description For Non-Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**
Hospice	100% of Contract Rate Limitations apply; refer to Plan SPD; **Deductible does not apply**	100% of Allowable Charges Limitations apply; refer to Plan SPD; **Deductible does not apply**
Routine Health Exams Preventative Health Care	80% of Contract Rate up to a maximum benefit of $300 per calendar year*; **Deductible applies** *Charges applied to the $300 calendar year maximum are the combined total of PPO and Non-PPO charges for routine preventive health care. Charges for immunizations are included in routine preventive care	60% of Allowable Charges up to a maximum benefit of $300 per calendar year*; **Deductible applies** *Charges applied to the $300 calendar year maximum are the combined total of PPO and Non-PPO charges for routine preventive health care. Charges for immunizations are included in routine preventive care
Routine Female Care		
Examinations	80% of Contract Rate*; **Deductible applies**	60% of Allowable Charges*; **Deductible applies**
Pap Tests	80% of Contract Rate*; **Deductible applies**	60% of Allowable Charges*; **Deductible applies**
Mammogram	80% of Contract Rate*; **Deductible applies** * The combined maximum benefit for all PPO and Non-PPO charges for routine female care is limited to $300 per calendar year	60% of Allowable Charges*; **Deductible applies** *The combined maximum benefit for all PPO and Non-PPO charges for routine female care is limited to $300 per calendar year
Well Baby Care	80% of Contract Rate up to a maximum benefit of $600 per calendar year*; **Deductible applies** *Charges applied to the $600 calendar year maximum are the combined total of PPO and Non-PPO charges for well baby care and immunizations	60% of Allowable Charges up to a maximum benefit of $600 per calendar year*; **Deductible applies** *Charges applied to the $600 calendar year maximum are the combined total of PPO and Non-PPO charges for well baby care and immunizations
Substance Abuse		
Inpatient	Not covered	Not covered
Outpatient	Not covered	Not covered
Mental Health		
Inpatient	Not covered	Not covered
Outpatient	Not covered	Not covered

Benefit Description For Non-Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**
Supplemental Accident Benefit	Not Applicable	100% of Allowed Charges incurred within 90-days of an accident up to $300 for medical and $100 for X-ray and lab services per accident; documentation must be provided to the Trust Fund Office. **Deductible does not apply** Charges remaining after the supplemental accident benefit has been paid will be subject to normal Plan provisions for Non-PPO claims – including coinsurance levels, calendar year deductible, and other applicable Plan provisions.
Vision Care **Vision Service Plan (VSP)** Customer Service: (800) 877-7195 Frequency Exam Glasses/Contact Lenses **Spectera/UnitedHealthcare Vision** Customer Service (800) 638-3120 Frequency Exam Glasses/Contact Lenses	 Exam and glasses (or contact lenses) are available every 12 months $25 co-payment $150 allowance Exam and lenses are available every 12 months, frame is available every 24 months. $10 co-payment each for exam and materials $130 allowance ($105 for contacts)	VSP and Spectera provide limited reimbursement, according to a schedule of allowances for exams and materials. Please contact your vision plan for more information.

Benefit Description For Non-Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**
PLEASE NOTE: If you are enrolled in the Fee-For-Service Plan and you are not participating in the Reinforcing Smart Choices Program (i.e. you and your covered spouse (or domestic partner) have not obtained a biometric screening or have not submitted your Participant Promise), then you will be in the BASIC PLAN and will be subject to the increased prescription drug co-payments effective January 1, 2014.		
Prescription Drug Coverage		
Retail 30-day Supply		
Generic Formulary	Premier Plan: $10 co-pay Basic Plan: $15 co-pay	Not Covered; limited exceptions for emergency prescriptions
Formulary Brand Name	Premier Plan: $20 co-pay Basic Plan: $35 co-pay	Not Covered; limited exceptions for emergency prescriptions
Non-Formulary Brand Name or Generic	Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug	Not Covered; limited exceptions for emergency prescriptions
Mail Order 90-day Supply		
Generic Formulary	Premier Plan: $20 co-pay Basic Plan: $30 co-pay	Not Covered; limited exceptions for emergency prescriptions
Formulary Brand Name	Premier Plan: $40 co-pay Basic Plan: $70 co-pay	Not Covered; limited exceptions for emergency prescriptions
Non-Formulary Brand Name or Generic	Not covered unless pre-authorization is obtained. If pre-authorized, paid as a formulary drug.	Not Covered

California Ironworkers Field Welfare Plan 1/1/2014 Open Enrollment Benefit Plan Comparison
Medicare Retired Participants Residing in Arizona

Benefit Description For Medicare Retirees	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	UnitedHealthcare Secure Horizons HMO Plan Benefits
Choice of Providers	Participants can use any provider; however, in order to receive the higher PPO Plan benefits, services must be received from an Anthem Blue Cross contracted provider. Medicare pays primary.	Services received from a non-Anthem Blue Cross provider are subject to the non-PPO level of benefits which could result in higher out-of-pocket expenses. Medicare pays primary.	Participants must go to a PacifiCare Secure Horizons provider and each family member may choose a different primary physician
Calendar Year Deductible	Not applicable	Not applicable	Not applicable
Lifetime Maximum	Not applicable	Not applicable	Not applicable
Annual Out of Pocket Maximum	$600 per person	$1,800 per person	$1,800 per person
Inpatient Hospital (including Physician Services)	$250 co-payment per admit	60% of Allowable Charges	$100 co-payment per admit
Emergency Care and ER Physicians Charges	90% of Allowed Amount after a $100 co-payment (waived if admitted)	90% of Allowable Charges after a $100 co-payment (waived if admitted)	$50 co-payment
Emergency Ground Ambulance	90% of Allowed Amount after a $50 co-payment	90% of Allowable Charges after a $50 co-payment	$50 co-payment
Urgent Care	90% of Allowed Amount after a $20 co-payment	60% of Allowable Charges after a $20 co-payment	$35 co-payment
Skilled Nursing Facility ***** Not subject to the Out-of-Pocket Maximum.	45% of Allowed Amount up to 55 days per disability and admission must occur after a 5-day or more inpatient hospital stay; patient must be admitted to the SNF within 7-days of the hospital discharge*	35% of Allowable Charges up to 55 days per disability and admission must occur after a 5-day or more inpatient hospital stay; patient must be admitted to the SNF within 7-days of the hospital discharge*	Days 1-20: No co-payment Days 21-100: $25 co-payment
Home Health Care	90% of Allowed Amount	60% of Allowable Charges	No co-payment per Medicare guidelines
Physician Office/Home Visits	90% of Allowed Amount after a $20 co-payment	60% of Allowable Charges after a $20 co-payment	Primary Care $5 co-payment Specialist $20 co-payment
Hospice	100% of Allowed Amount	100% of Allowable Charges	Covered under Medicare
X-ray and Lab	90% of Allowed Amount	60% of Allowable Charges	No co-payment

Benefit Description For Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**	**UnitedHealthcare Secure Horizons HMO Plan Benefits**
Outpatient Surgery	90% of Allowed Amount	60% of Allowable Charges Ambulatory Surgical Centers are limited to a maximum benefit of $350 per day; **Deductible applies**	$50 co-payment per surgery
Podiatry			
Exam	90% of Allowed Amount after a $20 co-payment	60% of Allowable Charges after a $20 co-payment	$20 co-payment
Orthotic Appliance	90% of Allowed Amount	Not covered	Per Medicare guidelines
Chiropractic and Acupuncture			
Chiropractic	90% of Allowed Amount	60% of Allowable Charges	50%; Limited to 12 visits per calendar year
Acupuncture	90% of Allowed Amount	60% of Allowable Charges	Not covered
Outpatient Physical, Respiratory and Speech Therapy	90% of Allowed Amount	60% of Allowable Charges	No co-payment
Routine Preventative Care Exams	100% of Allowed Amount with no maximum calendar year benefit	60% of Allowable Charges up to a maximum calendar year benefit of $300	No co-payment
Immunizations	90% of Allowed Amount	60% of Allowable Charges	No co-payment
Periodic Female Care			
Examinations	100% of Allowed Amount with no maximum calendar year benefit	60% of Allowable Charges up to a maximum calendar year benefit of $300	No co-payment
Pap Tests/Mammogram	100% of Allowed Amount with no maximum calendar year benefit	60% of Allowable Charges up to a maximum calendar year benefit of $300	No co-payment
Care for Allergies			
Office Visit/Testing	90% of Allowed Amount after a $20 co-payment	60% of Allowable Charges after a $20 co-payment	$5 co-payment / No co-payment
Treatment and Serum	90% of Allowed Amount	60% of Allowable Charges	No co-payment
Durable Medical Equipment			
Prosthetics, Orthopedic Braces, Other Equipment and Supplies	90% of Allowed Amount	60% of Allowable Charges	80%

Benefit Description For Medicare Retirees	Fee-For-Service PPO Contract Provider Benefits	Fee-For-Service PPO Non-Contract Provider Benefits	UnitedHealthcare Secure Horizons HMO Plan Benefits
Hearing Care			
Exams	100% of Allowed Amount up to a maximum benefit of $100 per calendar year	100% of Allowable Charges up to a maximum benefit of $100 per calendar year	No co-payment
Hearing Aids	100% of Allowed Amount (Allowed Amount is limited to $2,000 per device)*; limited to coverage once every three years from the date of the last purchase. Your payments made towards allowable charges above the cap do not apply towards your out-of-pocket maximum.	100% of Allowed Amount (Allowed Amount is limited to $2,000 per device)*; limited to coverage once every three years from the date of the last purchase. Your payments made towards allowable charges above the cap do not apply towards your out-of-pocket maximum.	$500 allowance for every 36 months
Substance Abuse			
Inpatient	Not covered	Not covered	$100 co-payment per admit
Outpatient	Not covered	Not covered	Individual: $20 co-payment Group: $5 co-payment
Mental Health			
Inpatient	Not covered	Not covered	$100 co-payment per admit limited to 190-days per lifetime
Outpatient	Not covered	Not covered	Individual: $20 co-payment Group: $5 co-payment

Benefit Description For Medicare Retirees	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	UnitedHealthcare Secure Horizons HMO Plan Benefits
Vision Care **Vision Service Plan (VSP)** Frequency Exam Glasses/Contact Lenses **Spectera/UnitedHealthcare Vision** Frequency Exam Glasses/Contact Lenses	Customer Service: (800) 877-7195 Exam and glasses (or contact lenses) are available every 12 months $25 co-payment $150 allowance Customer Service (800) 638-3120 Exam and lenses are available every 12 months, frame is available every 24 months. $10 co-payment each for exam and materials $130 allowance ($105 for contacts)	VSP and Spectera provide limited reimbursement, according to a schedule of allowances for exams and materials. Please contact your vision plan for more information.	Exam: $20 co-payment (includes glaucoma testing) Glasses/Contact Lenses: $75 allowance (Medicare covered after a cataract surgery) Covered in lieu of glasses Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount; See Fee-For-Service Benefits
Prescription Drugs **Retail** Generic Preferred Brand Name Non-Preferred Brand Name **Mail Order** Generic Preferred Brand Name Non-Preferred Brand Name	30 days supply $10 co-payment $20 co-payment $40 co-payment 90 days supply $20 co-payment $40 co-payment $80 co-payment	Not covered Not covered	See Fee-For-Service benefits See Fee-For-Service benefits See Fee-For-Service benefits See Fee-For-Service benefits See Fee-For-Service benefits See Fee-For-Service benefits

DENTAL BENEFITS			
Benefit Description for Medicare and Non-Medicare Retirees (additional premium required for all plans)	**Fee for Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Assurant Employee Benefits HMO Dental Plan**
Choice of Providers	Participants can visit any licensed dentist, however costs are lowest when visiting a Delta Dental PPO Dentist. If participants do not choose to use a Delta Dental PPO Dentist, they still have access to a Delta Dental Premier Dentist. You may pay more when seeing a Premier dentist than a PPO dentist, but still have cost protections that are not available when visiting a non-Delta Dental dentist. Delta Dental Customer Service (800) 765-6003	Participants must use an authorized DeltaCare USA HMO Dental Provider DeltaCare USA Customer Service (800) 422-4234	Participants must use an authorized Assurant Employee Benefits HMO Dental Provider Assurant Employee Benefits Customer Service (800) 443-2995
Calendar Year Deductible	$50 per person $150 per family	Not Applicable	Not Applicable
Maximum Calendar Year Benefit	PPO network: $3,000 per person Premier network: $2,000 per person Out-of-network: $1,500 per person Limits do not apply to pediatric dental services to age 19	No Maximum	No Maximum
Diagnostic, Preventative, Basic and Major Covered Services	PPO network: 100% for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees Premier network: 100% for Diagnostic & Preventative; 80% for Basic and Major services based on Delta Dental Premier contracted fees Out-of-Network: 80% for Diagnostic & Preventative; 50% for Basic and Major services based on Delta standard non-par reimbursement for non-Delta Dental dentists	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information Members must receive all services from their assigned DeltaCare USA provider.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information
Orthodontia	Plan pays 50% of Delta Dental PPO contracted fees up to a lifetime maximum of $1,000 for dependent children only	Orthodontic Extractions $0-$90 co-payment Enrollee Cost $1,900 co-payment for Comprehensive Adult Treatment and $1,700 for Comprehensive Child Treatment Orthodontic Takeover Covered	Members receive a 25% discount from the Orthodontist