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

Benefit Description For Non-Medicare Retirees	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	Health Plan of Nevada HMO Plan Benefits
Choice of Providers	If you live in Nevada, 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.	Participants must go to a Health Plan of Nevada provider and each family member may choose a different primary physician
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.	Not Applicable
Lifetime Maximum	$1,000,000	$1,000,000	Not Applicable
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.	Not Applicable
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.	Not Applicable

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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.		See the Evidence of Coverage booklet provided by Health Plan of Nevada.
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 Charges	80% of Contract Rate **Deductible applies**	60% of Allowed Charges **Deductible applies**	100% after a $75 co-payment (waived if admitted)
Emergency Ground Ambulance	80% of Contract Rate; **Deductible applies**	80% of Allowed Charges; **Deductible applies**	100% after a $50 co-payment
Urgent Care	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**	100% after a $15 co-payment
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***	$100 co-payment per day up to a maximum co-payment of $200 per admission and up to 100 days per calendar year
Home Health Care	80% of Contract Rate **Deductible Applies**	60% of Allowable Charges **Deductible Applies**	Physician: 100% after a $20 co-payment Private Duty Nurse: no co-payment and requires pre-authorization
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.	$100 co-payment per day up to a maximum co-payment of $200 per admission Physician: $100 co-payment per surgery Anesthesia: $150 co-payment per surgery

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Physician Office Visits	80% of Contract Rate; **Deductible applies**	60% of Allowed Charges; **Deductible applies**	100% after a $10 co-payment
Physician Home Visits	80% of Contract Rate; **Deductible applies**	60% of Allowed Charges; **Deductible applies**	100% after a $20 co-payment
X-ray and Lab Services	80% of Contract Rate; **Deductible applies**	60% of Allowed Charges; **Deductible applies**	Routine: No co-payment
Podiatry Exam Orthotic Appliances	80% of Contract Rate; **Deductible applies** Not covered	60% of Allowed Charges; **Deductible applies** Not covered	100% after a $10 co-payment; prior authorization required $500 per device up to a maximum lifetime benefit of $10,000
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.	Chiropractic: 100% after a $10 co-payment Prior authorization is required Acupuncture: Not covered
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.	100% after a $50 co-payment per surgery for facility 100% after a $50 physician surgical services Anesthesia: $150 per surgery
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.	100% after a $50 co-payment per surgery for facility 100% after a $50 physician surgical services Anesthesia: $150 per surgery

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Complex Imaging (MRI, PET & CT scans)	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**	100% after a $40 co-payment (PET Scan $750 per test)
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.	100% after a $10 co-payment; Limitations apply All short term rehab is subject to a maximum benefit of 60 days / visits per member per calendar day
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	100% after a $10 co-payment Limitations apply
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.	DME: $100 or 50% of EME of purchase price or rental price whichever is less. Prosthetics & Orthotic Devices: $500 per device up to a maximum lifetime benefit of $10,000 including repairs Medical Supplies: No charge
Chemotherapy/Radiation	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**	$40 per day in addition to office visit co-pay
Family Planning			
Infertility	Not covered	Not covered	$40 co-payment / consultation only
Vasectomy (reversal is not covered)	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**	100% (covered under preventive services)
Tubal Ligation (reversal is not covered)	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**	$100 co-payment for inpatient facility
Elective Abortions	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**	Not covered

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Care for Allergies			
Office Visit	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**	100% after a $10 co-payment
Testing	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**	100% after a $10 co-payment
Treatment and Serum	80% of Contract Rate; **Deductible applies**	60% of Allowable Charges; **Deductible applies**	100% after a $10 co-payment
Immunizations	Covered under routine care and preventive healthcare	Covered under routine care and preventive healthcare	No co-payment
Hearing Care			
Exams	100% of Contract Rate up to a maximum benefit of $100 per calendar year* **Deductible does not apply**	100% of Allowable Charges up to a maximum benefit of $100 per calendar year **Deductible does not apply**	100% after a $10 co-payment Exam only
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 last purchase** **Deductible does not apply** *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 maximum Allowed Amount of $2,000 per device are the total of all contract and non-contract charges for hearing aid devices.	100% of Allowed Amount (Allowed Amount is limited to $2,000 per device)*; limited to coverage once every three years from the date of last purchase** **Deductible does not apply** *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.	$100 or 50% of EME, whichever is less. Limited to a maximum benefit of $5,000 per member per calendar year & further limited to a single purchase, repairs & replacements limited to once every 3 years.
Hospice	100% of Contract Rate Limitations apply; refer to Plan SPD **Deductible Does Not Apply**	100% of Allowed Charges Limitations apply; refer to Plan SPD **Deductible Does Not Apply**	Inpatient: $100 co-payment per day up to a maximum co-payment of $200 per admission No co-payment for outpatient respite care up to a maximum benefit of $1,000 per calendar year

Benefit Description For Non-Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**	**Health Plan of Nevada HMO Plan Benefits**
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 Allowed Charges up to $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	100% after a $10 co-payment No charge for preventive care
Routine Female Care			
Examinations	80% of Contract Rate*; **Deductible Applies**	60% of Allowed Charges*; **Deductible Applies**	100% after a $10 co-payment diagnostic visit No co-payment (Preventive Care Services)
Pap Tests	80% of Contract Rate*; **Deductible Applies**	60% of Allowed Charges*; **Deductible Applies**	No co-payment (Preventive Care Services)
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 Allowed 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	No co-payment (Preventive Care Services)
Well Baby/Child Care	80% of Contract Rate up to a $600 per calendar year maximum benefit*; **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 Allowed Charges up to a $600 per calendar year maximum benefit*; **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	No co-payment (Preventive Care Services)
Substance Abuse			
Inpatient	Not covered	Not covered	$100 co-payment per day up to a maximum co-payment of $200 per admission
Outpatient	Not covered	Not covered	100% after a $10 co-payment per visit

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Mental Health			
Inpatient	Not covered	Not covered	$100 co-payment per day up to a maximum co-payment of $200 per admission
Outpatient	Not covered	Not covered	100% after a $10 co-payment per visit
Supplemental Accident Benefit	Not Applicable	100% of Allowable 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.	Not covered
Vision Care		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: $10 co-payment
Vision Service Plan (VSP)	Customer Service: (800) 877-7195		Glasses/Contact Lenses: Not covered
Frequency	Exam and glasses (or contact lenses) are available every 12 months		Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount; See Fee-For-Service Benefits
Exam	$25 co-payment		
Glasses/Contact Lenses	$150 allowance		
Spectera/UnitedHealthcare Vision	Customer Service (800) 638-3120		
Frequency	Exam and lenses are available every 12 months, frame is available every 24 months.		
Exam	$10 co-payment each for exam and materials		
Glasses/Contact Lenses	$130 allowance ($105 for contacts)		

Benefit Description For Non-Medicare Retirees	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	Health Plan of Nevada HMO Plan 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	$6 co-payment
Formulary Brand Name	Premier Plan: $20 co-pay Basic Plan: $35 co-pay	Not Covered; limited exceptions for emergency prescriptions	$12 co-payment
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	Not applicable
Mail Order 90-day Supply Generic Formulary	Premier Plan: $20 co-pay Basic Plan: $30 co-pay	Not Covered; limited exceptions for emergency prescriptions	$12 co-payment
Formulary Brand Name	Premier Plan: $40 co-pay Basic Plan: $70 co-pay	Not Covered; limited exceptions for emergency prescriptions	$24 co-payment
Non-Formulary Brand Name or Generic	Not covered unless pre-authorization is obtained. If pre-authorized, paid as a formulary drug.	Not Covered	Not applicable

Benefit Description For Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**	**Health Plan of Nevada Senior Dimensions Choice Plus HMO Plan 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 Health Plan of Nevada Senior Dimensions provider and each family member may choose a different primary physician	Participants must go to a UnitedHealthcare Secure Horizons provider and each family member may choose a different primary physician
Calendar Year Deductible	Not applicable	Not applicable	Not applicable	Not applicable
Lifetime Maximum	Not applicable	Not applicable	Not applicable	Not applicable
Annual Out of Pocket Maximum	$600 per person	$1,800 per person	$2,500 per person	$1,800 per person
Inpatient Hospital (including Physician Services)	$250 co-payment per admit	60% of Allowed Charges	No co-payment	$100 co-payment per admit
Emergency Room & ER Physicians Charges	90% of Allowed Amount after a $100 co-payment; Waived if admitted	90% of Allowed Charges after a $100 co-payment; Waived if admitted	$25 co-payment	$50 co-payment Waived if admitted
Emergency Ground Ambulance	90% of Allowed Amount after a $50 co-payment	90% of Allowable Charges after a $50 co-payment	No co-payment	$50 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	Days 1-20: No co-payment Days 21-100: $25 co-payment
Home Health Care	90% of Allowed Amount	60% of Allowed Charges	No co-payment	No co-payment per Medicare guidelines

Benefit Description For Medicare Retirees	**Fee-For-Service Contract Provider Benefits**	**Fee-For-Service Non-Contract Provider Benefits**	**Health Plan of Nevada Senior Dimensions Choice Plus HMO Plan Benefits**	**UnitedHealthcare Secure Horizons HMO Plan Benefits**
Physician Office/Home Visits	90% of Allowed Amount after a $20 co-payment	60% of Allowable Charges after a $20 co-payment	$5 co-payment	Primary Care: $5 co-payment Specialist: $20 co-payment
Hospice	100% of Allowed Amount	100% of Allowable Charges	No co-payment	Covered under Medicare
X-ray and Lab	90% of Allowed Amount	60% of Allowable Charges	No co-payment	No co-payment
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**	No co-payment	$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	$15 co-payment up to 4 self referrals per calendar year	$20 co-payment
Orthotic Appliance	90% of Allowed Amount	Not covered	Maximum benefit payable is 20% of Medicare approved charges	Per Medicare guidelines
Chiropractic and Acupuncture				
Chiropractic	90% of Allowed Amount	60% of Allowable Charges	$15 co-payment	50%; Limited to 12 visits per calendar year
Acupuncture	90% of Allowed Amount	60% of Allowable Charges	Not covered	Not covered
Outpatient Physical, Respiratory and Speech Therapy	90% of Allowed Amount	60% of Allowable Charges	$15 co-payment Limitations apply	No co-payment
Routine Preventative Care Exams	100% of Allowed Amount with no maximum calendar year benefit	60% of the Allowable Charges up to a maximum calendar year benefit of $300	No co-payment Limitations apply	No co-payment
Immunizations	100% of Allowed Amount	60% of Allowable Charges	No co-payment	No co-payment

Benefit Description For Medicare Retirees	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	Health Plan of Nevada Senior Dimensions Choice Plus HMO Plan Benefits	UnitedHealthcare Secure Horizons HMO Plan Benefits
Periodic Female Care				
Examinations	100% of Allowed Amount with no maximum calendar year benefit	60% of Allowabled Charges up to a maximum calendar year benefit of $300	No co-payment	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	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	$10 co-payment
Treatment and Serum	90% of allowed amount	60% of Allowable Charges	No co-payment	$10 co-payment
Durable Medical Equipment				
Prosthetics	90% of allowed amount	60% of Allowable Charges	$0 co-payment except for insulin pumps & associated supplies than 20% of Medicare approved charges	20%
Orthopedic Braces	90% of allowed amount	60% of Allowable Charges	20% of Medicare approved charges	
Other equipment and supplies	90% of allowed amount	60% of Allowable Charges	No co-payment	
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	Not covered Up to 40% discount with Plan providers	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.	See Medicare Retiree Fee-For-Service	$500 allowance for every 36 months

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Substance Abuse				
Inpatient	Not covered	Not covered	No co-payment	$100 co-payment per admit
Outpatient	Not covered	Not covered	$15 co-payment	Individual: $20 co-payment Group: $5 co-payment
Mental Health				
Inpatient	Not covered	Not covered	No co-payment	$100 co-payment per admit Limited to 190-days per lifetime
Outpatient	Not covered	Not covered	$15 co-payment	Individual: $20 co-payment Group: $5 co-payment
Vision Care		VSP and Spectera provide limited reimbursement, according to a schedule of allowances for exams and materials. Please contact your vision plan for more information.	Not covered	Exam: $20 co-payment (includes glaucoma testing)
Vision Service Plan (VSP)	Customer Service: (800) 877-7195		Vision benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount; See Fee-For-Service Benefits	
Frequency	Exam and glasses (or contact lenses) are available every 12 months			Glasses/Contact Lenses: $75 allowance (Medicare covered after a cataract surgery)
Exam	$25 co-payment			Covered in lieu of glasses
Glasses/Contact Lenses	$150 allowance			Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount; See Fee-For-Service Benefits
Spectera/UnitedHealthcare Vision	Customer Service (800) 638-3120			
Frequency	Exam and lenses are available every 12 months, frame is available every 24 months.			
Exam	$10 co-payment each for exam and materials			
Glasses/Contact Lenses	$130 allowance ($105 for contacts)			

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Prescription Drugs				
Retail	30 days supply	Not covered	31 days supply	
Generic	$10 co-payment		No co-payment for preferred generic $6 co-payment for non-preferred generic	See Fee-For-Service benefits
Preferred Brand Name	$20 co-payment		$35 co-payment	See Fee-For-Service benefits
Non-Preferred Brand Name	$40 co-payment		$60 co-payment	See Fee-For-Service benefits
Mail Order	90 days supply	Not covered	90 days supply	
Generic	$20 co-payment		No co-payment for preferred generic $6 co-payment for non-preferred generic	See Fee-For-Service benefits
Preferred Brand Name	$40 co-payment		$35 co-payment	See Fee-For-Service benefits
Non-Preferred Brand Name	$80 co-payment		Not covered	See Fee-For-Service benefits

DENTAL BENEFITS		
Benefit Description (additional premium required for all plans)	**Fee-For-Service Dental Plan** **Contract Provider Benefits**	**DeltaCare USA** **HMO Dental Plan**
Choice of Providers	Participants can visit any licensed dentists, 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
Calendar Year Deductible	$50 per person $150 per family	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
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.
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 (Comprehensive Adult Treatment): $1,900 co-payment Enrollee Cost (Comprehensive Child Treatment): $1,700 co-payment Orthodontic Takeover Covered