California Ironworkers Field Welfare Plan 1/1/2015 Open Enrollment Benefit Plan Comparison
Active A-Rodman Plan (No Dependent Coverage)

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Contract Provider Network and Choice of Providers	If you live in California, your Contract Provider Network is the Anthem Blue Cross Prudent Buyer network. If you live outside of California, or if you are travelling outside California, your network of hospitals and doctors is the National BlueCard network. **Participants who use a Contract Provider will pay less for services.**	If you use a physician or other Provider who is not in the Contract Provider Network, you are using a Non-Contract Provider. Participants who use a Non-Contract 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. Note: the combined out-of-pocket maximums and deductible (cost sharing) comply with the cost sharing limitations of the ACA.	**Individual: $250*** Does not apply to physician office visits, preventive care, prescription drugs, x-ray & lab (unless performed at hospital), chiropractic and acupuncture, outpatient therapy, outpatient mental health and substance abuse, emergency ground ambulance, urgent care, physician home visits, exams for podiatry, hearing exams, hearing aids, hospice care, office visit for allergy care, and excluded services. Deductible does not apply towards Annual Out-of-Pocket Limit.	**Individual: $500*** Deductible applies to most services. Does not apply to balance billed amounts, emergency ground ambulance, hearing exams, hearing aids, hospice care, supplemental accident, and excluded services.
Calendar Year Maximum Benefit	Not applicable	
Annual Out-Of-Pocket Limit for Medical	**Individual: $2,000** Expenses that do not count towards the Out-of-Pocket Limit include expenses you pay for skilled nursing facility, non-covered services (i.e. excluded services), vision care, dental care, orthodontia, expenses in excess of benefit maximums, balance billed amounts, and expenses for services from Non-Contract Providers. The Out-of-Pocket Limit for cost sharing includes co-payments and coinsurance. The Deductible does not apply towards the Annual Out-of-Pocket Limit.	**None** This means that your out-of-pocket expenses are not subject to any limits if you use Non-Contract Providers.

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Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Contract Rate and 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. Non-Contract Providers often bill more than the Plan's Allowable Charges. For Non-Contract Providers, the Plan generally pays 60% of the Allowable Charges. You pay 40% of the Allowable Charges and any billed charges over the Plan's Allowable Charge.
Description of co-payment and Co-insurance	• **Co-payments** are fixed dollar amounts (for example, $20) that you pay for covered health care; usually at the time you receive the services. • **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the services provided. The Plan generally pays a percentage of the medical expenses and you (and not the Plan) are responsible for paying the rest.	
Pre-Authorization and Pre-Certification Requirements	Certain services and procedures require pre-authorization from Pacific Health Alliance ("PHA") or pre-certification from Anthem. Inpatient mental health and substance abuse services require pre-authorization from MHN. 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; call (800) 274-7767 prior to your hospitalization. In most cases, your physician's office will arrange for the pre-certification of your hospital stay. For **Inpatient mental health and substance abuse**, services must be pre-authorized by MHN. For pre-authorization from MHN call: (800) 977-7962.	
➔	**Outpatient surgeries and procedures,** and **various other services**, require pre-authorization from PHA (855) 754-7271.	

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Maximum Allowable Charges (MAC) Certain procedures have maximum limits on the amount that the Plan will use as the basis for payment for facility charges. Procedures with MAC limits are: **Inpatient Hospital:** • Total Hip Replacement • Total Knee Replacement **Outpatient Surgical Procedures:** • Arthroscopy • Cataract Surgery • Colonoscopy	For procedures with a MAC Limit, the Plan will apply benefits to the lesser of the MAC or the Contract Rate. If you use a value based provider, you are responsible for payment of your coinsurance applied to the lesser of the MAC or the Contract Rate. If you use a Contract Provider that is not a value based provider, you will also be responsible for charges above the MAC. You can call PHA for help finding a value based provider: (855) 754-7271 or you can contact our Benefit Information Center at (800) 527-4613 for assistance	For inpatient MAC procedures, you are responsible for payment of your coinsurance applied to the Allowable Charges, plus 100% of any amounts above the Allowable Charges. Allowable Charges will not be more than the MAC. For outpatient MAC procedures, the Plan will pay a maximum of $350 per day. This means that the Plan will never pay more than $350 for any outpatient procedure. You are responsible for all charges above the $350 per day maximum.
Value Based Sites	Value based sites are Anthem Contract Providers that have agreed to charge no more than the MAC limit for MAC procedures. Using a value based site will provide you with greater savings.	There are no value based sites with Non-Contract Providers

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<table>
<tr><th>Benefit Description</th><th>Fee-For-Service
Contract Provider Benefits</th><th>Fee-For-Service
Non-Contract Provider Benefits</th></tr>
<tr><td></td><td colspan="2">PLEASE NOTE: If you are not participating in the Reinforcing Smart Choices Program (i.e. you 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 co-payments for certain services.

BASIC PLAN participants are <u>required to pay a $50 co-payment plus 10% coinsurance (where applicable) per visit for services listed below if they are obtained from a Contract Provider.</u> Basic Plan participants will also have higher prescription drug co-payments. Please refer to the prescription drug benefit section for a list of co-payments applicable to prescription drugs.

Please review the benefit carefully before utilizing services. Call the Trust Fund Office at 1 (800) 527-4613 and speak to a Benefits Information Center Specialist if you have any questions.</td></tr>
<tr><td colspan="3">Services requiring $50 co-payment plus 10% coinsurance for Participants in the <u>Fee-For-Service Basic Plan</u>:

• Primary Care Physician Visits
• Specialists Visits
• Physician Home Visits
• Outpatient Mental Health/Substance Abuse
• X-Ray and Lab Services (non-Complex) – from facility other than hospital
• Outpatient Substance Abuse
• Podiatry Exam
• Chiropractic and Acupuncture
• Urgent Care

Services requiring $50 co-payment for Participants in the <u>Fee-For-Service Basic Plan</u>:

• Physical Therapy
• Respiratory Therapy
• Speech Therapy
• Occupational Therapy
• Office Visit for Allergy Care</td></tr>
<tr><td>Preventive Care, Well Baby and Routine Female Care</td><td>100% of Contract Rate
No Deductible or co-payment</td><td>60% of Allowable Charges
Deductible applies</td></tr>
</table>

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Emergency Room and ER Physician Charges *For participants with an Emergency Medical Condition ONLY.*	90% of Contract Rate after $100 co-payment per trip **Deductible applies**	90% of Allowable Charges* after $100 co-payment per trip **Deductible applies** **Participant coinsurance is limited to a maximum of $6,000 per person per occurrence. You are responsible for all charges above the Allowable Charges.** **If it is determined that the patient does not have an Emergency Medical Condition, payment will be reduced to 60% of the Allowable Charges, and the $6,000 coinsurance limit will not apply.*
Emergency Ground Ambulance	90% after a $50 co-payment per trip **Deductible does not apply**	90% after a $50 co-payment per trip **Deductible does not apply**
Urgent Care	Premier Plan: 90% of Contract Rate after a $20 co-payment Basic Plan: 90% of Contract Rate after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**
Skilled Nursing Facility (SNF) ***Participant payments for SNF do not accumulate to the out-of-pocket limit.***	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 after a $20 co-payment **Deductible applies**	60% of Allowable Charges **Deductible applies**
Inpatient Hospital (All services performed during inpatient stay)	90% of Contract Rate **Deductible applies** **Does not apply to inpatient MAC procedures. See MAC procedures listed directly below. Pre-certification by Anthem Blue Cross is required for all inpatient procedures under the Fee-for-Service Plan. To pre-certify your hospital stay, your physician's office should call Anthem Blue Cross at (800) 274-7767.**	60% of Allowable Charges **Deductible applies**

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Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Inpatient Hospital MAC Procedures **For these procedures only:** • Total hip replacement • Total knee replacement	90% of the lesser of $30,000 (MAC limit) or the Contract Rate **Deductible applies** Remember, if you use a **Value-Based Site**, the Hospital will hold its charges under $30,000. If you do not use a **Value-Based Site**, you will be responsible for payment of charges above the MAC. **Pre-certification by Anthem Blue Cross is required for all inpatient procedures under the Fee-for-Service Plan. To pre-certify your hospital stay, your physician's office should call Anthem Blue Cross at (800) 274-7767. Anthem can also provide a list of providers who are Value Based Sites.**	60% of the Allowable Charges. Allowable Charges will not be more than the MAC limit. **Deductible applies** After **Deductible**, you are responsible for your 40% Coinsurance and for all charges above Allowable Charges.
Physician Office Visits	Premier Plan: 90% of Contract Rate after a $20 co-payment Basic Plan: 90% of Contract Rate after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**
Physician Home Visits	Premier Plan: 90% of Contract Rate after a $20 co-payment Basic Plan: 90% of Contract Rate after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**
X-ray and Lab Services (non-Complex Imaging) in office or facilities other than hospitals	Premier Plan: 90% of Contract Rate after a $20 co-payment Basic Plan: 90% of Contract Rate after a $50 co-payment **Deductible does not apply** **X-rays performed outside of your physician's office require pre-authorization by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.**	60% of Allowable Charges **Deductible applies**

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Podiatry Exam	Premier Plan: 90% of Contract Rate after a $20 co-payment Basic Plan: 90% of Contract Rate after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**
Orthotic Appliances	80% of Contract Rate up to a maximum benefit of $200 per calendar year; **Deductible applies**	Not covered
Chiropractic and Acupuncture Services, Combined	Premier Plan: 90% of Contract Rate after a $20 co-payment Basic Plan: 90% of Contract Rate after a $50 co-payment Limited to 24 visits per calendar year **Deductible does not apply** **The 24 visits per calendar year maximum is a combined annual visit limit for all Contract Provider and Non-Contract Provider chiropractor and acupuncture services.**	60% of Allowable Charges Limited to 24 visits per calendar year **Deductible applies**
Outpatient Surgery Facility Fee For Procedures Not Subject to MAC (Outpatient procedures subject to MAC are: Arthroscopies, Cataract Surgeries, and Colonoscopies – See Below▼).	90% of Contract Rate **Deductible applies** **Pre-authorization is 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.

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Outpatient Surgery – MAC Procedures (Facility Fee) **MAC applies to the following three procedures:** • Arthroscopy • Cataract Surgery • Colonoscopy	90% of the lesser of the MAC limit or the Contract Rate; **Deductible applies** **MAC Limits are:** **For Arthroscopy: $6,000 per procedure** **For Cataract Surgery: $2,000 per procedure** **For Colonoscopy: $1,500 per procedure** Remember, if you use a **Value-Based Site**, the facility will hold its charges under the MAC limit. You are responsible for payment of any charges in excess of the MAC. **Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271. PHA can also direct you to a value based site.**	Maximum benefit of $350 per day for all Non-Contract outpatient surgical procedures; **Deductible applies** You are responsible for payment of any charges in excess of the Plan's maximum payment of $350 per day.
Physician/Surgeon Fee for Outpatient Surgery	90% of Contract Rate **Deductible applies** **Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.**	60% of Allowable Charges **Deductible applies**
Complex Services (not limited to MRI, PET & CT scans)	90% of Contract Rate **Deductible applies** **Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.**	60% of Allowable Charges **Deductible applies**

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Physical Therapy & Respiratory Therapy, Combined	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment Maximum benefit of 20 visits per calendar year (combined with Non-Contract Provider Benefits) **Deductible does not apply** **The 20 visits per calendar year maximum is a combined annual limit for all Contract Provider and Non-Contract Provider services.** **Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.**	60% of Allowable Charges Maximum benefit of 20 visits per calendar year (combined with Contract Provider Benefits) **Deductible applies**
Speech Therapy & Occupational Therapy, Combined	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment Maximum benefit of 20 visits per calendar year (combined with Non-Contract Provider Benefits) **Deductible does not apply** **The 20 visits per calendar year maximum is a combined annual limit for all Contract Provider and Non-Contract Provider services.** **Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.**	60% of Allowable Charges Maximum benefit of 20 visits per calendar year (combined with Contract Provider Benefits) **Deductible applies**
Medical Supplies, Orthopedic Braces, Prosthetic Appliances	80% of Contract Rate **Deductible applies** **Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service for equipment/supplies costing over $500. Call PHA at (855) 754-7271.**	60% of Allowable Charges **Deductible applies**

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Chemotherapy/Radiation	90% of Contract Rate **Deductible applies** **Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.**	60% of Allowable Charges **Deductible applies**
Care for Allergies		
Office Visit	Premier Plan: 100% of Contract Rate after a $20 co-payment Basic Plan: 100% of Contract Rate after a $50 co-payment **Deductible does not apply**	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	Generally covered under Preventive Physical Care, Well Baby or Routine Female Care.	Generally covered under Preventive Physical Care, Well Baby or Routine Female Care
Family Planning		
Infertility	Not Covered	Not Covered
Contraceptive Devices	100% of Contract Rate **Deductible does not apply**	60% of Allowable Charges **Deductible applies**
Vasectomy (reversal is not covered)	80% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**
Tubal Ligation (reversal is not covered)	100% of Contract Rate **Deductible does not apply**	60% of Allowable Charges **Deductible applies**
Elective Abortions	80% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**

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Hearing Care Exams	100% of Contract Rate Benefit limited to one exam per calendar year; **Deductible does not apply**	100% of Allowable Charges Benefit limited to one exam per calendar year; **Deductible does not apply**
Hearing Aids	90% of the lesser of: $2,000 per device or the Contract Rate; **Deductible does not apply** Coverage is limited to one device per ear, not more often than once every three years from the date of the last purchase. You are responsible for any charges above $2,000 per device. **Charges applied to the maximum Allowed Amount of $2,000 per hearing aid are the total of all Contract and Non-Contract charges.**	90% of the lesser of $2,000 per device or Allowable Charges; **Deductible does not apply** Coverage is limited to one device per ear, not more often than once every three years from the date of the last purchase. You are responsible for any charges above the Allowed Amount (the lesser of $2,000 per device or the Allowable Charges)
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**
Supplemental Accident Coverage	Not Applicable	100% of Allowable Charges Must be incurred within 90-days of accident up to a maximum payment of $300 for medical and $100 for x-ray and lab services per accident **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, calendar year deductible, and other applicable Plan provisions.

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Mental Health & Substance Abuse Services		
Mental Health – Inpatient (including Alternate Levels of Care)	90% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**
Outpatient	Premier Plan: 90% of Contract Rate after a $20 co-payment Basic Plan: 90% of Contract Rate after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**
Substance Abuse - Inpatient (including Alternate Levels of Care)	90% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**
Outpatient	Premier Plan: 90% of Contract Rate after a $20 co-payment Basic Plan: 90% of Contract Rate after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**
	All inpatient services (including Alternate Levels of Care) under the Fee-For-Service Plan, except emergency hospitalization, must be pre- authorized by MHN or you will pay an additional 10% co-insurance. The MHN telephone number is: (800) 977-7962.	

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VISION CARE **Vision Service Plan (VSP)**	**VSP Customer Service: (800) 877-7195**	VSP and Spectera provide limited reimbursement, according to a schedule of allowances, for exams and materials. Please contact the Fund Office for more information.
Frequency	Exam and glasses (or contact lenses) are available every 12 months, frames every 24 months (2nd pair of glasses available to Employee with additional $30 materials co-payment).	
Exam	$30 co-payment	
Glasses/Contact Lenses	$150 allowance	
Spectera/UnitedHealthcare Vision	**Spectera 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)	
	Vision benefits are available automatically at the same time you are enrolled in the Plan's Fee-for-Service medical benefits. Effective January 1, 2015, you will be able to "opt out" of the self-funded vision benefits (choose not to have vision coverage). Please note that if you do nothing, you will automatically be enrolled in vision coverage. Please contact the Trust Fund Office if you would like to drop (opt out of) vision coverage.	

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
Medical Plan Exclusions *This is only a partial list of the services, treatments and supplies that are not Covered by the Plan. Please refer to your Summary Plan Descriptions, plus all Summaries of Material Modifications, for more information about items that are excluded from coverage under the Plan*.	The following services and supplies are not covered by the Plan: • Any services or supplies that are not Medically Necessary, except as specifically covered; • Dental services and supplies, except as specifically covered; • Treatment for mental health disorders, except as specifically covered; • Accidental bodily injury or sickness arising out of, or in the course of, employment, including self-employment; • Cosmetic treatment or surgery and complications resulting from any such procedure, except for repair of damage caused by accidental bodily injury (restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury is not considered cosmetic); • Charges in excess of the Plan's Allowable Charges (refer to the SPD) or Maximum Allowable Charge (MAC); • Experimental or Investigative procedures; except as required by health care reform laws; • Orthopedic shoes or other wearing apparel, except as specifically covered; • Vitamins, health foods, dietary supplements, consultations regarding food or nutrition, diabetic training and education, except as specifically covered; • Exercise equipment, whirlpools, Jacuzzis, saunas, pillows, non-prescription items, any over-the-counter, none-custom braces or supports; • Custodial care; • Reversal of sterilization; • All services related to infertility treatment; • All services related to any surrogate parenting arrangement; • Charges related to the treatment of obesity, other than surgical intervention for morbid obesity; and • Charges for services provided outside the United States except for Emergency care.	
Right of Reimbursement: Third Party Claims	If you receives benefits from the Plan for bodily injuries or illnesses sustained from the acts or omissions of any third party, the Plan will have the right to be reimbursed in the event you recover all or any portion of the benefits paid by the Plan by legal action, settlement or otherwise, regardless of whether such benefits were paid by the Plan prior to or after the date of any such recovery. Please see your Summary Plan Description for more information.	

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Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits
	**PLEASE NOTE: If you are not participating in the *Reinforcing Smart Choices Program* (i.e. you 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.**	
Annual Out-Of-Pocket Limit for Prescription Drug	**Individual: $2,000**	**None**
Retail 30-day Supply		
Generic Formulary	Premier Plan: $10 co-payment Basic Plan: $15 co-payment	Not Covered; limited exceptions for emergency prescriptions
Formulary Brand Name	Premier Plan: $20 co-payment Basic Plan: $35 co-payment	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-payment Basic Plan: $30 co-payment	Not Covered; limited exceptions for emergency prescriptions
Formulary Brand Name	Premier Plan: $40 co-payment Basic Plan: $70 co-payment	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

DENTAL BENEFITS	
Benefit Description	**Fee-For-Service Dental Plan** **Contract Provider Benefits**
Choice of Providers	Participants can visit any licensed dentist, however costs are lowest when visiting a Delta Dental PPO Dentist. If participants do not 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 you still have cost protections that are not available when visiting a non-Delta Dental dentist. **Delta Dental Customer Service: (800) 765-6003**
Calendar Year Deductible	$50 per person
Maximum Calendar Year Benefit	PPO network: $3,000 per person Premier network: $2,000 per person Out-of-network: $1,500 per person
Orthodontia	Not Covered.
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% of Allowed Amount for Diagnostic & Preventative; 50% of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates for non-Delta Dental dentists. **Dental benefits are available automatically at the same time you are enrolled in the Plan's Fee-for-Service medical benefits plan. Effective January 1, 2015, you will be able to "opt out" of the Fee-for-Service dental benefits (choose not to have dental coverage). Please note that if you do nothing, you will automatically be enrolled in dental coverage. Please contact the Trust Fund Office if you would like to drop (opt out of) dental coverage.**