California Ironworkers Field Welfare Plan 1/1/2015 Open Enrollment Benefit Plan Comparison
Active Participants Residing in Nevada

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	Health Plan of Nevada HMO Plan 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 or your dependents 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.	Participants must use a Health Plan of Nevada (HPN) provider. Services rendered by non-HPN providers are not covered, except in cases of emergency. 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. Note: the combined out-of-pocket maximums and deductible (cost sharing) comply with the cost sharing limitations of the ACA.	**Individual: $250*** **Family: $500*** 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, supplemental accident, and excluded services. Deductible does not apply towards Annual Out-of-Pocket Limit.	**Individual: $500*** **Family: $1,500*** Does not apply to balance billed amounts, emergency ground ambulance, hearing exams, hearing aids, hospice care, supplemental accident, and excluded services.	Not Applicable
Calendar Year Maximum Benefit	Not Applicable		Not Applicable

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	Health Plan of Nevada HMO Plan Benefits
Annual Out-Of-Pocket Limit for Medical	**Individual: $2,000** **Family: $4,000** 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.	**Individual: $6,000** **Family: $12,000** The Out-of-Pocket Maximum does not include: 1) amounts charged for non-covered services; 2) amounts exceeding applicable Plan benefit maximums or EME payments; or 3) penalties for not obtaining any required prior authorization or for the Member otherwise not complying with HPN's Managed Care Program.
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.	Not Applicable

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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.		Prior authorization means a system that requires a Provider to get approval from HPN before providing non-emergency healthcare services to a Member for those services to be considered Covered Services.
➔	**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.		
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.		

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Benefit Description	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 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 co-payments for certain services. Participants enrolled in the Health Plan of Nevada HMO can obtain free biometric screenings; however, your plan enrollment will not be affected if you choose not to participate. **BASIC PLAN participants are <u>required to pay a $50 co-payment 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.**			
Services requiring $50 co-payment for Participants in the <u>Fee-For-Service Basic Plan</u>: • **Primary Care Physician Visits** • **Specialists Visits** • **Physician Home Visits** • **Outpatient Mental Health** • **Outpatient Substance Abuse** • **X-Ray and Lab Services (non-Complex) - from facility other than hospital** • **Podiatry Exam** • **Chiropractic and Acupuncture** • **Urgent Care** • **Physical Therapy** • **Respiratory Therapy** • **Speech Therapy** • **Occupational Therapy** • **Office Visit for Allergy Care**			**Not Applicable**
Preventive Care, Well Baby and Routine Female Care	100% of Contract Rate **No Deductible or co-payment**	60% of Allowable Charges **Deductible applies**	No charge (Preventive Care Services)

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Emergency Room and ER Physician Charges *For participants with an Emergency Medical Condition ONLY.*	90% of Contract Rate **Deductible applies**	90% of Allowable Charges **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.*	$200 per visit (waived if admitted)
Emergency Ground Ambulance	100% after a $50 co-payment per trip **Deductible does not apply**	100% after a $50 co-payment per trip **Deductible does not apply**	$200 co-payment per trip
Urgent Care	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**	$25 co-payment per visit
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**	$300 per admission; waived if admitted from an acute care facility. Limited to 100 days per calendar year (per member)
Home Health Care	90% of Contract Rate after a $20 co-payment **Deductible applies**	60% of Allowable Charges **Deductible applies**	$35 co-payment per visit for Physician/Nurse (requires pre-authorization)

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Inpatient Hospital (All services performed during inpatient stay)	90% of Contract Rate **Deductible applies** **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**	$500 per admission for hospital $100 per surgery for physician services
Physician Office Visits	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**	$20 per primary care visit $40 per specialist care visit; $10 per visit for PA or PE; a $10 per visit for convenient care; $10 per visit for telemedicine
Physician Home Visits	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**	$20 co-payment
X-ray and Lab Services (non-Complex Imaging) in office or facilities other than hospitals	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% 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**	$10 co-payment for lab $25 co-payment for x-ray

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Podiatry			
Exam	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**	$40 co-payment (Referral required)
Orthotic Appliances	80% of Contract Rate up to a maximum benefit of $200 per calendar year; **Deductible applies**	Not covered	$50 co-payment per device. Subject to a maximum benefit. Limited to a single purchase of a type of orthotic device, including repair & replacement once every three years.
Chiropractic and Acupuncture Services, Combined	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment Limited to 24 visits per calendar year **Deductible does not apply**	60% of Allowable Charges **Deductible applies** Limited to 24 visits per calendar year	Chiropractic: $20 co-payment up to a maximum benefit of 20 visits per member, per calendar year Acupuncture: Not covered
	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.		
Outpatient Surgery Facility Fee (All services performed as Outpatient)	90% of Contract Rate **Deductible applies**	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.	$250 co-payment per surgery at a hospital facility $100 co-payment per surgery at ambulatory surgical facility $150 co-payment per surgery for anesthesia
	Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.		

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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**	$100 per surgery for inpatient or outpatient hospital facility $50 per surgery at ambulatory surgical facility
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**	$100 co-payment per test
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**	$20 co-payment per visit for outpatient; limitations apply* Inpatient Therapy: $300 per admission* * All inpatient and outpatient short term rehab services are subject to a combined max benefit of 120 days/visits per member per calendar year

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	Health Plan of Nevada HMO Plan Benefits
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**	60% of Allowable Charges Maximum benefit of 20 visits per calendar year (combined with Contract Provider Benefits) **Deductible applies**	$20 co-payment per visit for outpatient; limitations apply* Inpatient Therapy: $300 per admission* * All inpatient and outpatient short term rehab services are subject to a combined max benefit of 120 days/visits per member per calendar year
	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.		
Medical Supplies, Orthopedic Braces, Prosthetic Appliances	80% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**	DME: No charge; Purchases are limited to a single purchase of a type of DME, including repairs and replacement for every three years Prosthetics Devices: $750 co-payment per device. Purchases are limited to a single purchase of a type of prosthetic device, including repairs & replacement once every three years. Medical Supplies: No charge
	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.		
Chemotherapy/Radiation	90% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**	$20 per day co-payment in addition to office visit co-payment
	Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271.		

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Care for Allergies			
Office Visit	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**	$20 co-payment per visit
Testing	80% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**	$20 co-payment per visit
Treatment and Serum	80% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**	$20 co-payment per visit
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	No Charge (Preventive Care Services)
Family Planning			
Infertility	Not Covered	Not Covered	$40 co-payment per visit / consultation only
Contraceptive Devices	100% of Contract Rate **Deductible does not apply**	60% of Allowable Charges **Deductible applies**	100% (covered under preventive services)
Vasectomy (reversal is not covered)	80% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**	$100 co-payment for inpatient facility (Physician Surgical Services) $50 co-payment for outpatient facility (Physician Surgical Services)
Tubal Ligation (reversal is not covered)	100% of Contract Rate **Deductible does not apply**	60% of Allowable Charges **Deductible applies**	100% (covered under preventive services)
Elective Abortions	80% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**	Not covered

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	Health Plan of Nevada HMO Plan Benefits
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**	$20 co-payment (exam only)
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.	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).	No charge; Limited to a single purchase of a type of hearing aid, including repairs & replacement once every three years.
	Charges applied to the maximum Allowed Amount of $2,000 per hearing aid are the total of all Contract and Non-Contract 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**	Inpatient: $500 per admission Inpatient Respite Services: $500 per admission; Outpatient Respite Services: $40 per visit, subject to maximum benefit Benefits are limited to a combined maximum benefit of five inpatient days or five outpatient visits per member per 90 days of Home Hospice Care.

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	Health Plan of Nevada HMO Plan Benefits
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.	Not Applicable

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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**	$500 per admission
Outpatient	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**	$20 co-payment per visit
Substance Abuse - Inpatient (including Alternate Levels of Care)	90% of Contract Rate **Deductible applies**	60% of Allowable Charges **Deductible applies**	$500 per admission
Outpatient	Premier Plan: 100% after a $20 co-payment Basic Plan: 100% after a $50 co-payment **Deductible does not apply**	60% of Allowable Charges **Deductible applies**	$20 co-payment per visit
	Coverage for mental health services is available to the employee and eligible dependents. Substance Abuse benefits are only available to employees (no dependent coverage). 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)** Frequency Exam Glasses/Contact Lenses **Spectera/UnitedHealthcare Vision** Frequency Exam Glasses/Contact Lenses	**VSP Customer Service: (800) 877-7195** Exam and glasses (or contact lenses) are available every 12 months (2nd pair of glasses available to Employee only with additional $25 materials co-payment, not dependents). $25 co-payment $150 allowance **Spectera 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 the Fund Office for more information.	Exam Only: No Charge Glasses/Contact Lenses: Covered under VSP or Spectera See Fee-For-Service Benefits **VSP Customer Service** **(800) 877-7195** **Spectera Customer Service** **(800) 839-3242**
	Vision benefits are available automatically at the same time you are enrolled in the Plan's Fee-for-Service medical benefits or in the Health Plan of Nevada HMO plan. 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 (and any eligible dependents) will automatically be enrolled in vision coverage. Please contact the Trust Fund Office if you would like to drop (opt out of) vision coverage for yourself and any eligible dependents.		
Arbitration of Disputes	Not Applicable	Not Applicable	Please refer to the Evidence of Coverage Booklet for Health Plan of Nevada.

Benefit Description	Fee-For-Service Contract Provider Benefits	Fee-For-Service Non-Contract Provider Benefits	Health Plan of Nevada HMO Plan 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); • 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.		Please refer to the Evidence of Coverage booklets provided by Health Plan of Nevada.
Right of Reimbursement: Third Party Claims	If you or your Dependent 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 and/or your Dependent recovers all of 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.		Please refer to the Evidence of Coverage booklets provided by Health Plan of Nevada.

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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.			
Annual Out-Of-Pocket Limit for Prescription Drug	**Individual: $2,000** **Family: $4,000**	**None**	Prescription drug co-payments accrue toward the medical out-of-pocket.
Retail 30-day Supply			
Generic Formulary	Premier Plan: $10 co-payment Basic Plan: $15 co-payment	Not Covered; limited exceptions for emergency prescriptions	Tier I: $7 co-payment
Formulary Brand Name	Premier Plan: $20 co-payment Basic Plan: $35 co-payment	Not Covered; limited exceptions for emergency prescriptions	Tier II: $30 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	Tier III: $50 co-payment
Mail Order 90-day Supply			
Generic Formulary	Premier Plan: $20 co-payment Basic Plan: $30 co-payment	Not Covered; limited exceptions for emergency prescriptions	Tier I: $17.50 co-payment
Formulary Brand Name	Premier Plan: $40 co-payment Basic Plan: $70 co-payment	Not Covered; limited exceptions for emergency prescriptions	Tier II: $75 co-payment
Non-Formulary Brand Name or Generic	Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug.	Not Covered	Tier III: $125 co-payment Coverage is restricted to HPN Formulary Drug. Mandatory Generic benefit provision. The member will pay the Covered Co-payment plus the difference between the EME of the Generic Covered drug and the EME of the brand name.

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DENTAL BENEFITS			

Benefit Description	Fee-For-Service Dental Plan Contract Provider Benefits	DeltaCare USA 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 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**	Participants must use an authorized DeltaCare USA HMO Dental Provider **DeltaCare USA Customer Service: (800) 422-4234** ***Note:*** *DeltaCare USA HMO Dental Plan dentists are not the same as Delta Dental PPO Dentist or a Delta Premier PPO Dentist.*
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 when obtained at a PPO or Premier provider.	No Maximum
Orthodontia	Plan pays 50% of Delta Dental PPO contracted fees up to a lifetime maximum of $1,000 for dependent children only.	Ortho Extractions: $0-$90 co-payment Enrollee co-payment: • Comprehensive Adult Treatment: $1,900 • Comprehensive Child Treatment: $1,700 Orthodontic Takeover: 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 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.

Dental benefits are available automatically at the same time you are enrolled in the Plan's Fee-for-Service medical benefits or in the Health Plan of Nevada HMO plan. Effective January 1, 2015, you will be able to "opt out" of dental benefits (choose not to have dental coverage). Please note that if you do nothing, you (and any eligible dependents) will automatically be enrolled in dental coverage. Please contact the Trust Fund Office if you would like to drop (opt out of) dental coverage for yourself and any eligible dependents.

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