California Ironworkers Field Welfare Plan 1/1/2021 Open Enrollment Benefit Plan Comparison
Active Participants in the Fee-for-Service Plans

Please refer to the Schedule of Medical Benefits for a detailed comparison and description of the Fee-for-Service medical plan benefits (including prescription drugs and mental health/substance abuse treatment) for the Active Plan, Z-Coverage and the A-Rodman Plan. After you meet the eligibility requirements of the Fund, you (and any covered Dependents) will be eligible for the Active Plan coverage (unless your employer has elected to report less than the full hourly health and welfare contribution). Please contact the Trust Fund Office if you have questions regarding your plan of coverage.

Not all plan options may be available for all active participants and their Dependents as choices are based on your applicable Collective Bargaining Agreement and your state of residence.

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Deductible • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits. • The deductible is never waived. However, some services are not subject to the Deductible as noted in the Schedule of Medical Benefits. • **Note:** Deductible does not accumulate to the Annual Out-of-Pocket Limit. However, the combined Out-of-Pocket Maximum on cost sharing (deductible and Out-of-Pocket Maximum) complies with the cost sharing limitations of the ACA. • Allowed Charges incurred in the last quarter of the calendar year will be used to satisfy each individual's deductible in the following calendar year. • If two or more family members are injured in the same accident, only one deductible will apply.	**The deductible does not apply to:** • **For Contract Providers:** physician office visits (including co-payments), 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. • **For Non-Contract Providers:** balance billed amounts, emergency ground ambulance, hearing exams, hearing aids, hospice care, supplemental accident and excluded services. **Note:** Any Deductible accumulated while you are not enrolled in the wellness program do **NOT** carry over if and when you chose to participate in the wellness program. **Note**: Contract provider and non-contract provider deductibles are combined.	$250 Individual $500 Family	$500 Individual $1,500 Family	$500 Individual $1,500 Family	$750 Individual $2,250 Family	$250 Individual $500 Family	$500 Individual $1,500 Family

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Out-of-Pocket Limit The Out-of-Pocket Limit is the most you pay during a one year period (the calendar year) before your health plan starts to pay 100% for covered health benefits received from Contract providers. The Out-of-Pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's out-of-pocket limit applicable to an individual with self-only coverage.	The Out-of-Pocket Limit for cost sharing includes medical co-payments and coinsurance. The Deductible does not accumulate to the Annual Out-of-Pocket Limit. Expenses that do not count towards the Out-of-Pocket Limit for cost sharing includes: expenses you pay for skilled nursing facility, non-covered services (i.e. excluded services), vision care, dental care, orthodontia, penalties for failure to comply with pre-authorization requirements, expenses in excess of benefit maximums, balance billed amounts, and expenses for services from Non-Contract Providers. There are separate Out-of-Pocket Limits for medical services and prescription Drugs. **NOTE:** any Out-of-Pocket amounts accumulated while you are not participating in the wellness program do **NOT** carry over if an when you choose to enroll.	**Medical** $2,000 Individual $4,000 Family **Prescription Drugs** $2,000 Individual $4,000 Family	Unlimited	**Medical** $1,000 Individual $3,000 Family **Prescription Drugs** $1,000 Individual $3,000 Family	Unlimited	**Medical** $2,000 Individual $4,000 Family **Prescription Drugs** $2,000 Individual $4,000 Family	Unlimited

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Hospital Services Inpatient Coverage includes: • Room and board up to the hospital's average semiprivate room rate and care in an intensive care unit and cardiac care unit, when Medically Necessary; • Hospital services and supplies provided during admission, including surgical suite, imaging procedures, laboratory tests, and therapeutic treatments; • Diagnostic, surgical, or therapeutic services provided by a hospital on an inpatient basis; • Surgery and postoperative care rendered by a Physician in a hospital; • Anesthetics and their administration; and • Services and supplies related to the surgical procedure performed.	• Does not apply to MAC inpatient procedures. **See Hospital Services for MAC procedures listed on the Schedule of Medical Benefits.** • Pre-certification by Anthem Blue Cross is required for all inpatient procedures or you will pay an additional 10% coinsurance. To pre-certify your hospital stay, your physician's office should call Anthem Blue Cross at (800) 274-7767. • Services rendered by an assistant surgeon are covered if Medically Necessary.	10% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	10% member coinsurance after deductible	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Inpatient Hospital MAC Procedures • Room and board up to the hospital's average semiprivate room rate and care in an intensive care unit and cardiac care unit, when Medically Necessary; • Hospital services and supplies provided during admission, including surgical suite, imaging procedures, laboratory tests, and therapeutic treatments; • Diagnostic, surgical, or therapeutic services provided by a hospital on an inpatient basis; • Surgery and postoperative care rendered by a Physician in a hospital; • Anesthetics and their administration; and • Services and supplies related to the surgical procedure performed.	**The following inpatient MAC limits do not apply to Arizona or Nevada Participants:** • Pre-certification by Anthem Blue Cross is required for all inpatient procedures or you will pay an additional 10% coinsurance. 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 The following inpatient procedures have maximum limits on the amount that the Plan will use as the basis for payment for facility charges. The MAC limits are: • **Total hip replacement** $30,000 per procedure • **Total knee replacement:** $30,000 per procedure Services rendered by an assistant surgeon are covered if Medically Necessary.	10% member coinsurance of the lesser of $30,000 (MAC limit) or the Contract Rate after deductible	40% member coinsurance after deductible (will not exceed MAC limit)	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance of the lesser of MAC limit or Contract Rate after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance of the lesser of MAC limit or Contract Rate after deductible	40% member coinsurance after Deductible (will not exceed MAC limit)	10% member coinsurance of the lesser of $30,000 (MAC limit) or the Contract Rate after deductible	40% member coinsurance after Deductible (will not exceed MAC limit)

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Physician Office Visits and Physician Home Visits • Physicians' services to diagnose or treat an illness or injury that are provided in your Physician's office, a hospital, other facility, or at home are covered.		**If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment Deductible does not apply	40% member coinsurance after deductible
LiveHealth Online Telehealth Benefit		No co-payment Deductible does not apply	No co-payment Deductible does not apply	No co-payment Deductible does not apply	No co-payment Deductible does not apply	No co-payment Deductible does not apply	No co-payment Deductible does not apply

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Allergy Services	• Medically Necessary allergy services are covered only when ordered by a Physician.	**Office Visit** **If you participate in the Reinforcing Smart Choices program:** $20 co-payment (deductible does not apply) **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment (deductible does not apply) **Allergy Testing, Treatment and Serum** 20% member coinsurance after deductible	40% member coinsurance after deductible	**Office Visit** **If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible **Allergy Testing, Treatment and Serum** 20% member coinsurance after deductible	40% member coinsurance after deductible	**Office Visit** **If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment and the deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment and the deductible **Allergy Testing, Treatment and Serum** 20% member coinsurance after deductible	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Ambulance Services **(Ground vehicle emergency transportation)** • Local professional ambulance service is covered subject to a Co-payment (shown in the Schedule of Benefits) when the medical condition of the patient requires paramedic support. • In the event an injury or illness requires treatment that is not available in a local hospital, the Plan covers medically required ambulance service to the nearest hospital that can provide appropriate treatment.	• Transportation that is solely for the participant's convenience, personal preference (including taxi, limousine, railroad, or other non-emergency vehicle) will not be covered.	$50 co-payment. Deductible does not apply	$50 co-payment. Deductible does not apply	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	10% member coinsurance after a $50 co-payment. Deductible does not apply	10% member coinsurance after a $50 co-payment. Deductible does not apply
Ambulance **(Air Ambulance)** • Medically Necessary air ambulance is generally provided by and covered as a Non-Contract provider.		20% member coinsurance of billed charges after the deductible		30% member coinsurance of billed charges after deductible		20% member coinsurance of billed charges after the deductible	

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Chemotherapy or Radiation • Radium, radioactive isotopes, and radiation therapy.	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	10% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after Deductible	40% member coinsurance after deductible	10% member coinsurance after deductible	40% member coinsurance after deductible
Chiropractic and Acupuncture Services Combined	• Limited to a combined annual visit limit of 24 visits for all Contracted and Non-Contracted providers	**If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 20% member coinsurance after a $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment Deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Drugs (Coverage of Prescription Drugs) through OptumRx • Coverage is provided for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician authorized by law to prescribe them. • The **mail-order program is mandatory for maintenance medication**. After your 3rd prescription at a retail pharmacy for maintenance medication, you will be charged two Co-payments for one prescription. You save money by using the mail order prescription drug program for your long-term medication needs. • Member specialty drug customer service (855) 427-4682	**Out of Pocket Maximum for prescription drugs** ***Active Plan:*** $2,000 Individual, $4,000 Family ***Z coverage***: $1,000 Individual, $3,000 Family ***A-Rodman***: $2,000 Individual, $4,000 Family **Retail 30-day Supply** **Generic Formulary/Specialty Drug** If you participate in the Reinforcing Smart Choices program: $10 co-payment If you do NOT participate in the Reinforcing Smart Choices program: $15 co-payment **Formulary Brand Name/Specialty Drug** If you participate in the Reinforcing Smart Choices program: $20 co-payment If you do NOT participate in the Reinforcing Smart Choices program: $35 co-payment **Non-Formulary Brand Name or Generic/Specialty Drug** Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. **Mail Order 90-day Supply** **Generic Formulary** If you participate in the Reinforcing Smart Choices program: $20 co-payment If you do NOT participate in the Reinforcing Smart Choices program: $30 co-payment **Formulary Brand Name** If you participate in the Reinforcing Smart Choices program: $40 co-payment If you do NOT participate in the Reinforcing Smart Choices program: $70 co-payment **Non-Formulary Brand Name or Generic** Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)						

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Drugs (Coverage Of Certain Over The Counter (OTC) Drugs) Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of OTC drugs, this Plan will comply with the new requirements on the date required.	In accordance with Health Reform regulations, certain OTC drugs are payable by this non-grandfathered medical plan including: • Aspirin – Generic aspirin products are covered for men and women from age 45 to 79 years of age • Fluoride supplementation for children to 6 years of age • Folic Acid supplements for girls/women ages 10-55 years • Iron supplementation supplements for infants up to 1 year in age • Smoking cessation drugs for two 90-day regimens per calendar year • Contraceptives all forms of generic female contraceptives (oral, diaphragms, jelly, foams, implantable, etc.). No charge for brand name if generic drug is medically inappropriate.	**No charge** if purchased at a Network Pharmacy and a prescription is received **Not covered** if purchased at a Non-Network Pharmacy					

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Employee Assistance Program (EAP) through MHN • The EAP can also provide telephonic counseling for such work-life issues as child and elder care, financial counseling, brief legal counseling and identity theft. Online assessments and referrals are also available for such issues as smoking cessation, weight loss and health risk assessments. • MHN customer services (800) 977-7962	• **This plan offers up to three free EAP visits per calendar year for professional confidential counseling. The phone number for the EAP program is listed on the Important Telephone Numbers chart in the front of this document.** • After an initial assessment, employees who require additional services will be referred to either a contracted substance abuse treatment program or mental health provider or to community resources. • Please note, you are **not** required to use your EAP visits prior to receiving additional services.	No charge	Not covered	No charge	Not covered	No charge	Not covered

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Emergency Room and Physician Charges • Hospital emergency room (ER) for an "emergency Medical Condition" only (as defined by the Plan)." • The term "Emergency Services" means a medical screening examination and medical treatment necessary to evaluate and stabilize an individual with an Emergency Medical Condition (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility). Emergency Services must be rendered in a hospital emergency room.	• As always, you do not have to obtain pre-authorization before seeking emergency room treatment for an Emergency Medical Condition, though you or your family must call Blue Cross the next working day after admission to the hospital. • If you obtain Emergency Services from a Non-Contract Provider, the Plan generally pays a percentage of the Allowable Charges. The Plan does not pay a percentage of actual charges. If the hospital's charges exceed the Plan's Allowable Charge, you will be responsible for the difference. • The Allowed Charge for Emergency Services provided by a Non-Contracting Provider will not be less than what is required by law. • Amounts paid by the Plan for an Emergency Medical Condition, whether rendered by a Contract Provider or a Non-Contract Provider, will count towards the Plan's out-of-pocket maximum.	10% member coinsurance after deductible	After deductible, 10% member coinsurance of the greatest of: • The median amount negotiated with in-network providers for the emergency service; • Allowed Charges/Allowable Charges; or • The amount that would be paid under Medicare for the emergency service. If it is determined, the patient does not have an Emergency Medical Condition, payment will be reduced to 40% member coinsurance and the $6,000 coinsurance limit will not apply.	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** After deductible, 20% member coinsurance of the greatest of the listed below. **If you do NOT participate in the Reinforcing Smart Choices program:** After Deductible, 30% member coinsurance of the greatest of the listed below: • The median amount negotiated with in-network providers for the emergency service; • Allowed Charges/Allowable Charges; or • The amount that would be paid under Medicare for the emergency service. Participant coinsurance limited to $6,000 per occurrence. If it is determined, the patient does not have an Emergency Medical Condition, payment will be reduced to 40% member coinsurance and the $6,000 coinsurance limit will not apply.	10% member coinsurance after $100 co-payment and deductible	After $100 co-payment and deductible, the greatest of: • The median amount negotiated with in-network providers for the emergency service; • Allowed Charges/Allowable Charges; or • The amount that would be paid under Medicare for the emergency service. Participant coinsurance limited to $6,000 per occurrence. If it is determined, the patient does not have an Emergency Medical Condition, payment will be reduced to 40% member coinsurance and the $6,000 coinsurance limit will not apply.

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Family Planning • No cost-sharing for female sterilization when performed by Contract providers • No cost sharing for FDA-approved female contraceptives	• Services for treatment of infertility are **not covered**. • Reversal of a tubal ligation or vasectomy is not covered.	**Contraceptive Devices, and Tubal Ligation** No charge Deductible does not apply **Vasectomy and Elective Abortions** 20% member coinsurance after deductible	40% member coinsurance after deductible (If a vasectomy or elective abortion is performed at a Non-contracted ambulatory surgery facility, maximum benefit of $350 per day after Deductible)	**Contraceptive Devices, and Tubal Ligation** No charge Deductible does not apply **Vasectomy and Elective Abortions** **If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible (If a vasectomy or elective abortion is performed at a Non-contracted ambulatory surgery facility, maximum benefit of $350 per day after Deductible)	**Contraceptive Devices, and Tubal Ligation** No charge Deductible does not apply **Vasectomy and Elective Abortions** 20% member coinsurance after deductible	40% member coinsurance after deductible (If a vasectomy or elective abortion is performed at a Non-contracted ambulatory surgery facility, maximum benefit of $350 per day after Deductible)

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Genetic testing	• Pre-authorization is required (except for screenings that are required to be covered under Health Reform) by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271.	**Office Visit** **If you participate in the Reinforcing Smart Choices program:** $20 co-payment, Deductible does not apply **If you participate in the Reinforcing Smart Choices program,** $50 co-payment, Deductible does not apply	40% member coinsurance after deductible	**Office Visit** **If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	**Office Visit** **If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment and the deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment and the deductible	40% member coinsurance after deductible
Hearing Care	• Exams are limited to one per calendar year. • Coverage is limited to one device per ear, not more often than once every three years from the date of the last purchase. • The $2,000 maximum per hearing aid is a combined maximum for all Contract and Non-Contract charges. • Replacement batteries are not covered.	**Exam** No charge Deductible does not apply **Hearing Aids** 10% member coinsurance of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam** No charge Deductible does not apply **Hearing Aids** 10% member coinsurance of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam** No charge Deductible does not apply **Hearing Aids** 20% member coinsurance of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exams** No charge Deductible does not apply **Hearing Aids** 20% member coinsurance of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam** No charge Deductible does not apply **Hearing Aids** 10% member coinsurance of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam** No charge Deductible does not apply **Hearing Aids** 10% member coinsurance of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Home Health Care		10% member coinsurance after deductible and a $20 co-payment	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	20% member coinsurance after deductible and a $20 co-payment.	40% member coinsurance after deductible
Hospice • Intermittent nursing care provided by a graduate registered nurse or licensed practical nurse under the supervision of a registered nurse for the terminally ill patient. Terminally ill means an individual with less than six months to live. • Medical social services provided prior to death by a licensed social worker • Bereavement counseling during the three-month period following the death of the terminally ill patient.		No charge Deductible does not apply	No charge Deductible does not apply	No charge Deductible does not apply	No charge Deductible does not apply	No charge Deductible does not apply	No charge Deductible does not apply

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Laboratory Services (in office or facility other than a Hospital)	Lab services performed outside of your physician's office require pre-authorization by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	**If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment Deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Medical Supplies, Orthopedic Braces, Prosthetic Appliances Subject to approval by the Trust Fund Office, rental (or purchase, if cost effective) of Medically Necessary supplies, equipment and prosthetics. Coverage includes: • Casts, splints, orthotic devices, braces, crutches, shoes for the treatment of foot disfigurement, and surgical dressings. • Blood, blood plasma, and its administration. • Oxygen and its administration. • Artificial limbs and eyes. • Breast prosthesis following a mastectomy; subsequent prosthesis ordered by a Physician. • Initial purchase of eyeglasses or contact lenses as a result of cataract surgery.	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271 for all medical supplies costing more than $500. • For females who are breastfeeding, coverage is provided for one standard manual or standard electric breast pump, plus the breast pump supplies needed to operate the breast pump. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Rental, purchase and repair is payable. • In lieu of a customized brace, the Fund will allow one over-the-counter brace if Medically Necessary, prescribed by a Physician and purchased within the first 31 days following a covered surgery or accident.	**Breast Pump** No charge Deductible does not apply **All other covered Medical Supplies, Orthopedic Braces and Prosthetic Appliances** 20% member coinsurance after deductible	40% member coinsurance after deductible	**Breast Pump** No charge Deductible does not apply **All other covered Medical Supplies, Orthopedic Braces and Prosthetic Appliances** **If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	**Breast Pump** No charge Deductible does not apply **All other covered Medical Supplies, Orthopedic Braces and Prosthetic Appliances** 20% member coinsurance after deductible	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Mental Health Treatment • Please also refer to the Substance Abuse Row for available benefits.	• Mental Health services are available through Managed Health Network (MHN). All inpatient services including alternate levels of care (except emergency hospitalization) must be pre-authorized by MHN or you will pay an additional 10% coinsurance. • In cases of emergency, the patient or a family member must contact MHN as soon as possible, but no later than 72 hours after an inpatient admission at (800) 977-7962. • No benefits are provided for pervasive developmental delay, learning disabilities or that are primarily provided to enhance academic achievement of Dependent children.	**Inpatient** 10% member coinsurance after deductible **Outpatient** **If you participate in the Reinforcing Smart Choices program:** $20 co-payment, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment, Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	**Inpatient** 10% member coinsurance after deductible **Outpatient** **If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment, Deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Outpatient Surgery Facility for Procedures not Subject to MAC • Ambulatory (Outpatient) Surgical Facility/Center (e.g. surgicenter, same day surgery, outpatient surgery).	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	10% member coinsurance after deductible	Maximum benefit of $350 per day after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	Maximum benefit of $350 per day after deductible	10% member coinsurance after deductible	Maximum benefit of $350 per day after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Outpatient Surgery Facility Fee (for MAC procedures) The following outpatient procedures have maximum limits on the amount that the Plan will use as the basis for payment for Facility charges: • Arthroscopy • Cataract • Colonoscopy	The following MAC limits apply to ALL participants: • **Arthroscopy** $6,000 per procedure • **Cataract Surgery** $2,000 per procedure • **Colonoscopy** $1,500 per procedure Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271.	10% member coinsurance of the lesser of the MAC limit or the Contract Rate after deductible	Maximum benefit of $350 per day for all Non-Contract outpatient surgical procedures after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance of the lesser of the MAC limit or the Contract Rate after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance of the lesser of the MAC limit or the Contract rate after deductible	Maximum benefit of $350 per day for all Non-Contract outpatient surgical procedures after deductible	10% member coinsurance of the lesser of the MAC limit or the Contract Rate after deductible	Maximum benefit of $350 per day for all Non-Contract outpatient surgical procedures after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Outpatient Surgery Physician and/or Surgeon fee	Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	10% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	10% member coinsurance after deductible	40% member coinsurance after deductible
Physical Therapy and Respiratory Therapy, Combined • Only care that demonstrates progressive improvement in the patient's functional capacity is covered.	• Maximum benefit of 20 visits per calendar year (for all Contract and Non-Contract providers combined) • If pre-approved by case management as Medically Necessary, the Fund may allow 10 additional therapy visits after major surgery, stroke or a heart attack. • Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271. • No benefits are provided for pervasive developmental delay.	**If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 20% member coinsurance after a $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program,** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program,** $50 co-payment Deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Podiatry Exam	• Orthotic appliances are covered for the **Employee only**	**Office Visits** **If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply **Orthotic Appliances for Employee only** 20% member coinsurance after deductible up to a maximum benefit of $200 per calendar year	**Office Visits** 40% member coinsurance after deductible **Orthotic appliances** Not covered	**Office Visits** **If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible **Orthotic Appliances for Employee only** 20% member coinsurance after deductible up to a maximum benefit of $200 per calendar year	**Office Visits** 40% member coinsurance after Deductible **Orthotic Appliances** Not covered	**Office Visits** **If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment Deductible does not apply **Orthotic Appliances for Employee only** 20% member coinsurance after Deductible up to a maximum benefit of $200 per calendar year	**Office Visits** 40% member coinsurance after deductible **Orthotic Appliances** Not covered

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Radiology, X-ray (Complex Services) including but not limited to MRI, PET and CAT scans	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271	10% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	10% member coinsurance after deductible	40% member coinsurance after deductible
Radiology, X-ray (Non-Complex Services) in office or facilities other than Hospital • Diagnostic x-rays	• X-rays performed outside of your Physician's office require pre-authorization by calling Pacific Heath Alliance (PHA) Care Counseling Service. • Some radiology procedures are covered under the Preventive Care Program.	**If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment Deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Radiology, X-ray (Non-Complex Services) at a Hospital • Diagnostic x-rays	• X-rays performed at a Hospital require pre-authorization by calling Pacific Heath Alliance (PHA) Care Counseling Service. • Some radiology procedures are covered under the Preventive Care Program.	10% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	10% member coinsurance after deductible	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Reconstructive Services and Breast Reconstruction After Mastectomy This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including: • reconstruction of the breast on which the mastectomy was performed; • surgery and reconstruction of the other breast to produce a symmetrical appearance; and • prostheses and physical complications for all stages of mastectomy, including lymphedemas.	Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271 (or Anthem if the procedure is done in the Hospital as part of an inpatient confinement). The Plan will cover Medically Necessary reconstructive surgery, procedures or treatment intended to improve bodily function and/or correct a deformity resulting from disease, infection, trauma, or congenital anomaly in a child that causes a functional defect or results from a prior therapeutic procedure. Please contact the Trust Fund Office to determine if a proposed surgery or service will be considered cosmetic surgery or Medically Necessary. In order to determine Medical Necessity, the Plan reserves the right to request any and all medical records, including but not limited to: history and physical reports, chart notes, test results, operative reports, pathology reports and pre-operative color photos.	10% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	10% member coinsurance after deductible	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Skilled Nursing Facility (SNF) • Charges for room and board and other services and supplies, not including fees for professional services.	• Participant payments for SNF do not accumulate to the annual Out-of-Pocket maximum	55% member coinsurance after deductible up to 55 days per calendar year	65% member coinsurance after deductible up to 55 days per calendar year	55% member coinsurance after deductible up to 55 days per calendar year	65% member coinsurance after deductible up to 55 days per calendar year	55% member coinsurance after deductible up to 55 days per calendar year	65% member coinsurance after deductible up to 55 days per calendar year
Speech Therapy and Occupational Therapy combined	• Annual Maximum of 20 visits per calendar year for all Contract Provider and Non-Contract Provider Services. • If preauthorized by case management as Medically Necessary, the Fund may allow 20 additional therapy visits. • Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	**If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 20% member coinsurance after a $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Substance Abuse Treatment • Active Employees enrolled in an HMO may also receive these services.	• Substance abuse benefits are available for Active Employees only (not Dependents). • All inpatient services including alternative levels of care (except emergency hospitalization) must be pre-authorized by MHN (800) 977-7962 or you will pay an additional 10% coinsurance. • In cases of emergency, the patient or a family member must contact MHN as soon as possible, but no later than 72 hours after an inpatient admission at (800) 977-7962.	**Inpatient Care (including alternate levels of Care)** 10% member coinsurance after deductible **Outpatient Care** **If you participate in the Reinforcing Smart Choices program:** $20 co-payment, deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment, deductible does not apply	40% member coinsurance after deductible	**Inpatient Care (including alternate levels of Care)** **If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible **Outpatient Care** **If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program,** 30% member coinsurance after deductible	40% member coinsurance after deductible	**Inpatient Care (including alternate levels of Care)** 10% member coinsurance after deductible **Outpatient Care** **If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment, deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment, deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Supplemental Accident Coverage Covered Charges include: • Medical and surgical treatment; and/or • Hospital services. • Services provided by a registered nurse or physical therapist. • Laboratory and x-ray services related to the injury. • Injuries sustained to the teeth or gums related to the accident.	• Charges must be incurred within 90-days of accident (applied without respect to when the individual was enrolled in the Plan) up to $300 for medical and $100 for x-ray and lab services per accident. **There are no benefits available for:** • Treatment beginning after 90 days of the date the injury occurred. • Ptomaine poisoning. • Disease or infections other than those related to the injury. • Eye glasses. • Hearing aids. • Injuries sustained in an altercation, however, this exclusion does not apply to any injury that results from a medical condition or domestic violence.	Not Applicable	No charge, deductible does not apply up to maximum payments. Remaining covered charges are subject to normal Plan provisions for Non-Contract claims.	Not Applicable	No charge, deductible does not apply up to maximum payments. Remaining covered charges are subject to normal Plan provisions for Non-Contract claims.	Not Applicable	No charge, deductible does not apply up to maximum payments. Remaining covered charges are subject to normal Plan provisions for Non-Contract claims.

MEDICAL BENEFITS Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Temporomandibular Joint Dysfunction (TMJ) treatment	• Limited to a lifetime maximum of $1,000 per person.	**If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program,** 10% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program,** 10% member coinsurance after a $50 co-payment Deductible does not apply	40% member coinsurance after deductible
Urgent Care		**If you participate in the Reinforcing Smart Choices program:** $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** $50 co-payment Deductible does not apply	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 20% member coinsurance after deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 30% member coinsurance after deductible	40% member coinsurance after deductible	**If you participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 10% member coinsurance after a $50 co-payment Deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Wellness/Preventive Care for Children **Covered Services include but are not limited to:** • Newborn screening lab tests (typically payable as part of hospitalization at birth); • At least 11 office visits payable during first 30 months of age, then annual office visits are payable from age 3 years through age 18 years; • Hemoglobin and lead blood tests in first year of life; • Screening for hepatitis B virus infection; • Application of fluoride varnish to the primary teeth of all infants and children up to age 5 starting at the age of primary tooth eruption, in primary care practices; • Tuberculosis (TB) skin test in first year of life; • Hemoglobin blood test in second year of life; and • CDC recommended immunizations. See row titled "Weight Management" for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss. Where the information in this document conflicts with newly released Health Reform regulations affecting coverage, this Plan will comply with the new requirements on the date required.		No charge deductible does not apply	40% member coinsurance after deductible	No charge deductible does not apply	40% member coinsurance after deductible	No charge deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Wellness/Preventive Care for Men Covered Services include but are not limited to: • Abdominal aortic aneurysm screening; • Colonoscopy, sigmoidoscopy or fecal occult blood test beginning at age 50 (including anesthesia services, a pre-op consult and a pathology exam on a polyp biopsy provided in connection with the procedure). • Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV; • Screening for hepatitis B virus infection; • Tobacco Use screening for all adults and cessation interventions for tobacco users. This includes four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and • CDC recommended immunizations. See row titled "Weight Management" for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss. Where the information in this document conflicts with newly released Health Reform regulations affecting coverage, this Plan will comply with the new requirements on the date required.		No charge Deductible does not apply	40% member coinsurance after deductible	No charge Deductible does not apply	40% member coinsurance after deductible	No charge Deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Wellness/Preventive Care for Women (including pregnant women) Covered Services include but are not limited to: • Well women office visits; • Screening for gestational diabetes, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, rental/purchase of breastfeeding equipment and necessary supplies, lactation support (for duration of breastfeeding); • Sterilization procedures, patient education and counseling; • Many services necessary for prenatal care; • Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia; • Screening mammogram for breast cancer; • Pap smear and Chlamydia screening; • Osteoporosis screening x-ray; • Colonoscopy, sigmoidoscopy or fecal occult blood test beginning at age 50 (including anesthesia, pre-op consult and pathology exam on a polyp biopsy provided in connection with the procedure); • Blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV; • Screening for hepatitis B virus infection; • Tobacco use screening, cessation interventions for tobacco users and expanded counseling for pregnant tobacco users. This includes four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and • BRCA 1 and 2 lab test with family history of breast cancer See row titled "Weight Management" for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss. Where the information in this document conflicts with newly released Health Reform regulations affecting coverage, this Plan will comply with the new requirements on the date required.		No charge Deductible does not apply	40% member coinsurance after deductible	No charge Deductible does not apply	40% member coinsurance after deductible	No charge Deductible does not apply	40% member coinsurance after deductible

MEDICAL BENEFITS **Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.**							
Benefit Description	**Explanations and Limitations**	**Active Plan**		**Z Coverage**		**A Rodman**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Weight Management • Bariatric surgeries include a variety of procedures intended to assist significant weight loss, including but not limited to: lap-band surgery, gastric bypass surgery, and gastric banding surgery. • As a **preventive counseling benefit** in compliance with Health Reform, the Plan covers Physician prescribed intensive behavioral counseling interventions. Intensive behavioral counseling interventions. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician.	• Surgical treatments for Morbid Obesity (such as bariatric surgery may be covered under normal plan benefits (subject to any deductible, co-payments and/or coinsurance) if the surgery is performed at an Anthem Blue Distinction facility and is pre-authorized by Anthem. • Charges for weight loss programs such as Weight Watchers and Jenny Craig's are not covered.	**Preventive Counseling** No charge Deductible does not apply **Surgical treatment** is subject to normal plan benefits	40% member coinsurance after deductible	**Preventive Counseling** No charge Deductible does not apply **Surgical treatment** is subject to normal plan benefits	40% member coinsurance after deductible	**Preventive Counseling** No charge Deductible does not apply **Surgical treatment** is subject to normal plan benefits	40% member coinsurance after deductible

California Ironworkers Field Welfare Plan 1/1/2021 Open Enrollment Benefit Plan Comparison
Active Participants in the Fee-for-Service Plans

MEDICAL BENEFITS

Important: Contract Providers are paid according to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Vision Service Plan (VSP)	• Exams and lenses are available every 12 months, frames (or contact lenses) are also available every 12 months except A-Rodman for every 24 months • 2nd pair of glasses available to Employee only with additional $25 materials co-payments, except for A-Rodman members who have a $30 co-payment • VSP Customer Service: (800) 877-7195	**Exams** $25 co-payment **Frames/Contact Lenses** $150 allowance	VSP provides limited reimbursement, according to a schedule of allowances for exams and materials. Please contact the Fund Office for more information.	**Exams** $25 co-payment **Frames/Contact Lenses** $150 allowance	VSP provides limited reimbursement, according to a schedule of allowances for exams and materials. Please contact the Fund Office for more information.	**Exams** $30 co-payment **Frames/Contact Lenses** $150 allowance	VSP provides limited reimbursement, according to a schedule of allowances for exams and materials. Please contact the Fund Office for more information.
Spectera/UnitedHealthcare Vision	• Exams and lenses are available every 12 months, frames are available every 24 months. • 2nd pair of glass or contact lens is available. • Spectera Customer Service: (800) 638-3120	**Exams** $10 co-payment each for exams and materials **Frames (or Contact Lenses)** $130 allowance (or $105 allowance)	Spectera provides limited reimbursement, according to a schedule of allowances for exams and materials. Please contact the Fund Office for more information.	**Exams** $10 co-payment each for exams and materials **Frames (or Contact Lenses)** $130 allowance (or $105 allowance)	Spectera provides limited reimbursement, according to a schedule of allowances for exams and materials. Please contact the Fund Office for more information.	**Exams** $10 co-payment each for exams and materials **Frames (or Contact Lenses)** $130 allowance (or $105 allowance)	Spectera provides limited reimbursement, according to a schedule of allowances for exams and materials. Please contact the Fund Office for more information.

DENTAL BENEFITS FOR PARTICIPANTS RESIDING IN ARIZONA			
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Sun Life Financial HMO Dental**
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 Dentist.*	Participants must use an authorized Assurant Employee Benefits HMO Dental Provider **Assurant Employee Benefits Customer Service (800) 443-2995**
Deductible • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits	$50 per person $150 per family	Not Applicable	Not Applicable
Maximum Calendar Year Benefit • The Maximum Calendar Year Benefit is the most the Plan will pay during a calendar year for your covered dental benefits.	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	No Maximum

DENTAL BENEFITS FOR PARTICIPANTS RESIDING IN ARIZONA			
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Sun Life Financial HMO Dental**
Diagnostic, Preventative, Basic, and Majored Covered Services	**PPO Network**: No charge for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. **Premier Network**: No charge for Diagnostic & Preventative; 20% member coinsurance for Basic and Major services based on Delta Dental Premier contracted fees. **Out-of-Network**: 20% member coinsurance of Allowed Amount for Diagnostic & Preventative; 50% member coinsurance of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates 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.	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.	Ortho Extractions: $0 to $90 co-payment Enrollee Co-payment for: • Comprehensive Adult: $1,900 • Comprehensive Child: $1,700 Orthodontic Takeover: Covered	Members receive a 25% Discount from the Orthodontist

DENTAL BENEFITS FOR PARTICIPANTS RESIDING IN CALIFORNIA				
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Health Net HMO Dental Plan**	**United Concordia 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 Dentist.*	Participants must use an authorized Health Net HMO Dental Provider. **Health Net Dental Customer Service (800) 880-8113**	Participants must use an authorized United Concordia HMO Dental Provider. **UCCI HMO** **Customer Service: (866) 357-3304**
Deductible • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits	$50 per person $150 per family	Not Applicable	Not Applicable	Not Applicable
Maximum Calendar Year Benefit • The Maximum Calendar Year Benefit is the most the Plan will pay during a calendar year for your covered dental benefits.	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	No Maximum	No Maximum

DENTAL BENEFITS FOR PARTICIPANTS RESIDING IN CALIFORNIA				
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Health Net HMO Dental Plan**	**United Concordia HMO Dental Plan**
Diagnostic, Preventative, Basic, and Majored Covered Services	**PPO Network**: No charge for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. **Premier Network**: No charge for Diagnostic & Preventative; 20% member coinsurance for Basic and Major services based on Delta Dental Premier contracted fees. **Out-of-Network**: 20% member coinsurance of Allowed Amount for Diagnostic & Preventative; 50% member coinsurance of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates 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.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information.	Pre-authorization is not required 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.	Ortho Extractions: No co-payment Enrollee Cost (Comprehensive Adult or Child Treatment): $1,000 co-payment Orthodontic Takeover - is covered	$1,450 co-payment for participants, plus $250 co-payment for retention phase	$1,500 co-payment for children, $2,000 co-payment for adults; plus an additional $240 co-payment for retention phase and a $265 co-payment for records fee. Other copays may apply.

DENTAL BENEFITS FOR PARTICIPANTS RESIDING IN NEVADA		
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 Dentist.*
Deductible • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits	$50 per person $150 per family	Not Applicable
Maximum Calendar Year Benefit • The Maximum Calendar Year Benefit is the most the Plan will pay during a calendar year for your covered dental benefits.	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 Majored Covered Services	**PPO Network**: No charge for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. **Premier Network**: No charge for Diagnostic & Preventative; 20% member coinsurance for Basic and Major services based on Delta Dental Premier contracted fees. **Out-of-Network**: 20% member coinsurance of Allowed Amount for Diagnostic & Preventative; 50% member coinsurance 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 FOR PARTICIPANTS RESIDING IN NEVADA		
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**
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

DENTAL BENEFITS FOR ACTIVE MEMBERS ENROLLED IN				
	A-RODMAN PLAN	Z-COVERAGE PLAN		
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Sun Life Financial HMO Dental**
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 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 Dentist.*	Participants must use an authorized Assurant Employee Benefits HMO Dental Provider **Assurant Employee Benefits Customer Service (800) 443-2995**
Deductible • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits	$50 per person $150 per family	$50 per person $150 per family	Not Applicable	Not Applicable
Maximum Calendar Year Benefit • The Maximum Calendar Year Benefit is the most the Plan will pay during a calendar year for your covered dental benefits.	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.	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	No Maximum

DENTAL BENEFITS FOR ACTIVE MEMBERS ENROLLED IN				
	A-RODMAN PLAN	Z-COVERAGE PLAN		
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Sun Life Financial HMO Dental**
Diagnostic, Preventative, Basic, and Majored Covered Services	**PPO Network**: No charge for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. **Premier Network**: No charge for Diagnostic & Preventative; 20% member coinsurance for Basic and Major services based on Delta Dental Premier contracted fees. **Out-of-Network**: 20% member coinsurance of Allowed Amount for Diagnostic & Preventative; 50% member coinsurance of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates for non-Delta Dental dentists.	**PPO Network**: No charge for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. **Premier Network**: No charge for Diagnostic & Preventative; 20% member coinsurance for Basic and Major services based on Delta Dental Premier contracted fees. **Out-of-Network**: 20% member coinsurance of Allowed Amount for Diagnostic & Preventative; 50% member coinsurance of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates 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.	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.	Plan pays 50% of Delta Dental PPO contracted fees up to a lifetime maximum of $1,000 for dependent children only.	Ortho Extractions: $0 to $90 co-payment. Enrollee Co-payment for: • Comprehensive Adult: $1,900 • Comprehensive Child: $1,700 Orthodontic Takeover: Covered	Members receive a 25% Discount from the Orthodontist