California Ironworkers Field Welfare Plan 1/1/2021 Open Enrollment Benefit Plan Comparison
Retirees in HMO Plans

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	**Explanations and Limitations**	**Non-Medicare Retirees Residing in California**			**Non-Medicare Retirees Residing in Nevada**
		Kaiser Deductible HMO	**Health Net HMO**	**UnitedHealthCare HMO**	**Health Plan of Nevada HMO**
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.		$250 individual $500 Family	Not Applicable	Not Applicable	Not Applicable

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		Kaiser Deductible HMO	**Health Net HMO**	**UnitedHealthCare HMO**	**Health Plan of Nevada HMO**
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.	$3,000 Individual $6,000 Family	$2,000 Individual $6,000 Family	$2,000 Individual $4,000 Family	$6,000 Individual $12,000 Family 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.
Lifetime Maximum The Lifetime Maximum is the most your health plan will pay towards your healthcare costs during your lifetime.		Not Applicable	Not Applicable	Not Applicable	Not Applicable
Hospital Services Inpatient .		10% member coinsurance after deductible	30% member coinsurance	$500 co-payment per diem Applies to a maximum of 3 days per admission	$300 per admission Physician: $100 co-payment per surgery Anesthesia: $100 co-payment per surgery

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		Kaiser Deductible HMO	**Health Net HMO**	**UnitedHealthCare HMO**	**Health Plan of Nevada HMO**
Physician Office Visits and Physician Home Visits		$10 co-payment (deductible does not apply)	$40 co-payment Open Access: $60 co-payment	$20 co-payment	Office Visit $5 co-payment for PCP, PA, PE or Convenient Care Home Visit $35 co-payment per visit
Telehealth (Virtual Visits)		No co-payment	$40 co-payment	$20 co-payment	No co-payment
Allergy Services		**Office Visit** $10 co-payment **Testing** $10 co-payment **Treatment and Serum** No charge	**Office Visit** $40 co-payment **Testing** No co-payment (Open Access: $60 co-payment) **Treatment and Serum** No charge	**Office Visit** $20 co-payment ($40 co-payment for specialist) **Testing** $20 co-payment **Treatment and Serum** $20 co-payment for treatment No charge for serum	**Office Visit** $5 co-payment per visit **Testing** $5 co-payment per visit **Treatment and Serum** $5 co-payment per visit
Ambulance Services (Ground vehicle emergency transportation)		$150 co-payment (deductible does not apply)	$100 co-payment	$50 co-payment	$150 co-payment
Chemotherapy or Radiation		No charge	No charge	No co-payment for standard; 100% after a $50 co-payment for complex	$5 per day in addition to office visit co-payment
Emergency Room and Physician Charges		10% member coinsurance per visit after deductible (waived if admitted)	$100 co-payment (waived if admitted)	$100 co-payment (waived if admitted)	$150 co-payment (waived if admitted through a Hospital ER Facility)

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Chiropractic and Acupuncture Services Combined		**Chiropractic** Not covered **Acupuncture** $10 co-payment; covered as an alternative to standard treatment when prescribed by a Plan physician. It is primarily used as a component of a multidisciplinary pain management program for the treatment of chronic pain.	**Chiropractic** $10 co-payment up to 30 visits per year (through American Specialty Health). **Acupuncture** Not covered Discounts available through the Health Net Healthy Discount Program	**Chiropractic** $10 co-payment up to 20 visits per year **Acupuncture** Not covered	**Chiropractic** $5 co-payment; up to 20 visits per member per calendar year. (requires pre-authorization) **Acupuncture** Not covered
Family Planning	• Reversal of a tubal ligation or vasectomy is not covered	**Infertility** 50% member coinsurance of charges for diagnosis and treatment (does not accumulate toward out-of-pocket maximum) **Contraceptive Devices, and Tubal Ligation** $30 co-payment **Vasectomy and Elective Abortions** 10% member coinsurance after Deductible	**Infertility** 50% member coinsurance of charges for diagnosis and treatment **Contraceptive Devices** No charge **Tubal Ligation** No charge Vasectomy $50 co-payment **Elective Abortions** No co-payment	**Infertility** Not covered **Contraceptive Devices, and Tubal Ligation** No charge **Vasectomy** $50 co-payment **Elective Abortions** Up to 2nd trimester for $125 co-payment. After 20 weeks not covered unless life threatening	**Infertility** $10 co-payment / consultation only **Contraceptive Devices (No Charge), and Tubal Ligation** $100 co-payment for inpatient facility (Physician Surgical Services) **Vasectomy** $100 co-payment for inpatient facility (Physician Surgical Services) **Elective Abortions** Not covered

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		Kaiser Deductible HMO	**Health Net HMO**	**UnitedHealthCare HMO**	**Health Plan of Nevada HMO**
Prescription Drugs	• For Health Net and UnitedHealthcare enrollees, prescription drug coverage is provided through OptumRx.	**Retail 30-day Supply** Generic Formulary $10 co-payment Formulary Brand Name $30 co-payment Non-Formulary Brand Name or Generic Same as Formulary Specialty Drug $30 co-payment **Mail Order 90-day Supply** Generic Formulary $20 co-payment Formulary Brand Name $60 co-payment Non-Formulary Brand Name or Generic Same as Formulary	**Retail 30-day Supply** Generic Formulary $10 co-payment Formulary Brand Name $20 co-payment Non-Formulary Brand Name or Generic Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. **Mail Order 90-day Supply** Generic Formulary $20 co-payment Formulary Brand Name $40 co-payment Non-Formulary Brand Name or Generic Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. Provided under OptumRx. Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)	**Retail 30-day Supply** Generic Formulary $10 co-payment Formulary Brand Name $20 co-payment Non-Formulary Brand Name or Generic Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. **Mail Order 90-day Supply** Generic Formulary $20 co-payment Formulary Brand Name $40 co-payment Non-Formulary Brand Name or Generic Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. Provided under OptumRx. Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)	**Retail 30-day Supply** Tier I $7 co-payment (Low Cost Option) Tier II $30 co-payment (Midrange Cost Option) Tier III $50 co-payment (High Cost Option) **Mail Order 90-day Supply** Tier I $17.50 co-payment Tier II $75 co-payment Tier III $125 co-payment

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		Kaiser Deductible HMO	**Health Net HMO**	**UnitedHealthCare HMO**	**Health Plan of Nevada HMO**
Hearing Care	Fee-for-Service Hearing Aids • 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. • Allowed amount does not apply towards your out-of-pocket maximum. • Replacement batteries are not covered.	**Kaiser** Exam: $10 co-payment **Fee-for-Service Hearing Aids** No charge of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Health Net** Exam: $40 co-payment Open Access: $60 co-payment **Fee-for-Service Hearing Aids** No charge of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**UnitedHealthCare** Exam: $20 co-payment Specialist: $40 co-payment Hearing Aids: $50 Co-payment. $5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair/replacement) per hearing-impaired ear every three years. **Fee-for-Service Hearing Aids** No charge of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Health Plan of Nevada** Exam: $5 co-payment Hearing Aids: No charge and limited to a single purchase of a type of hearing aid, including repair and replacement once every three years **Fee-for-Service Hearing Aids** No charge of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply
Home Health Care		No co-payment for part time intermittent care when prescribed by a Plan physician Limited to 100 days per accumulation period	$40 co-payment The co-payment begins with first visit. Limited to 100 visits per calendar year	$10 co-payment Limited to 100 visits per calendar year	$35 co-payment for Physician/Nurse (requires pre-authorization)
Laboratory Services (in office or facility other than a Hospital)		$10 per encounter (deductible does not apply)	No co-payment	No co-payment	Routine lab: $5 co-payment Routine x-ray: $10 co-payment

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Hospice		No co-payment	No co-payment	$500 co-payment per day. Co-payment applies to a maximum 3 days per stay. (Prognosis of life expectancy is less than 1 year)	Inpatient $300 co-payment per admission Outpatient No charge Outpatient Respite $10 co-payment Inpatient/Outpatient Respite: Benefits are limited to a combined max benefit of five Inpatient days or five Outpatient visits per member, per 90 days of Home Hospice Care.
Outpatient Surgery		10% member coinsurance after deductible	30% member coinsurance	$250 co-payment	$50 co-payment per surgery for Ambulatory facility $200 co-payment per surgery for Hospital facility

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		Kaiser Deductible HMO	**Health Net HMO**	**UnitedHealthCare HMO**	**Health Plan of Nevada HMO**
Medical Supplies, Orthopedic Braces, Prosthetic Appliances		**Durable Medical Equipment** 20% member coinsurance; deductible does not apply (does not accumulate toward out-of-pocket maximum) **Orthopedic & Prosthetic** No co-payment	No co-payment	$50 co-payment	**Durable Medical Equipment** No charge (limited to a single purchase of a type of DME, including repair and replacement once every three years) **Orthopedic Devices** $50 co-payment per device **Prosthetics Devices** $750 co-payment per device. Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement once every three years. **Medical Supplies** No charge
Physical Therapy and Respiratory Therapy, Combined		$10 co-payment	$40 co-payment, limitations apply. Open Access: $60 co-payment	$40 co-payment (limitations apply)	$5 co-payment; Limitations apply Inpatient Hospital Facility: $300 per admission All inpatient and outpatient short term rehab is subject to a combined maximum benefit of 60 days / visits per member per calendar year

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		Kaiser Deductible HMO	**Health Net HMO**	**UnitedHealthCare HMO**	**Health Plan of Nevada HMO**
Mental Health Treatment		**Inpatient** 10% member coinsurance after deductible **Outpatient** Individual: $10 co-payment Group: $5 co-payment	**Inpatient** 20% member coinsurance per admit **Outpatient** Individual: $30 co-payment (non-severe) and $15 co-payment (severe) Group: $15 co-payment (non-severe) and $7.50 co-payment (severe) *Specific Mental Illness Diagnoses are covered with no day or visit limitations	**Inpatient** $250 co-payment per day up to a maximum of 3 days per stay per calendar year* **Outpatient** $40 co-payment* *Specific Mental Illness Diagnoses are covered with no day or visit limitations	**Inpatient** $300 co-payment per admission **Outpatient** $5 co-payment
Podiatry Exam		**Office Visits** $10 co-payment; if medically necessary. Deductible does not apply. **Orthotic Appliances** No co-payment	**Office Visits** $40 co-payment; if medically necessary Open Access: $60 co-payment **Orthotic Appliances** Covered only if incorporated into a cast, splint, brace or strapping of foot	**Office Visits** $20 office visit co-payment or a $40 specialist office visit co-payment ; if medically necessary **Orthotic Appliances** Covered only if incorporated into a cast, splint, brace or strapping of foot	**Office Visits** $10 co-payment **Orthotic Appliances** $50 co-payment per device. Limited to a single purchase of a type of orthotic device, including repair and replacement, once every three years.
Radiology, X-ray (Complex Services) including but not limited to MRI, PET and CAT scans		$50 co-payment	$100 co-payment	$50 co-payment	$100 co-payment per test

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Radiology, X-ray (Non-Complex Services) in office or facilities other than Hospital		$10 co-payment	No charge	No charge	**Routine Lab** $5 co-payment **Routine X-ray** $10 co-payment
Skilled Nursing Facility (SNF)	• Participant payments for SNF do not accumulate to the annual Out-of-Pocket maximum	10% member coinsurance (deductible does not apply) Limited to a maximum benefit of 100-days per benefit period	Days 1-10: No co-payment Days 11-100: $25 per day	$200 co-payment per day Apply to a maximum of 3 days per stay. Limited to 100-consecutive calendar days from the first treatment per disability.	$300 co-payment per admission and up to 100 days per member per calendar year; co-payment waived if admitted from an acute care facility.
Speech Therapy and Occupational Therapy combined		$10 co-payment. Limitations apply.	$40 co-payment. Limitations apply.	$40 co-payment. Limitations apply.	$5 co-payment; Limitations apply Inpatient Hospital Facility: $300 per admission All inpatient and outpatient short-term rehab is subject to a combined maximum benefit of 60 days / visits per member per calendar year.

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Substance Abuse Treatment		**Inpatient** 10% member coinsurance; deductible applies to Detoxification Only **Transitional Recovery Services** $100 per admission co-payment up to a maximum calendar year benefit of 60-days and no more than 120-days in a consecutive 5-year period in an approved non-residential facility **Outpatient** Individual: $10 co-payment Group: $5 co-payment	**Inpatient** 20% per admit **Outpatient** Individual: $30 co-payment Group: $15 co-payment	**Inpatient** $500 per day co-payment; Applied to a maximum of 3 days per stay **Transitional Recovery Services** Prior Authorization Required (800) 999-9585 Outpatient $40 co-payment No Dependent Coverage	**Inpatient** $300 co-payment per admission **Outpatient** $5 co-payment per visit
Urgent Care		$10 co-payment (deductible does not apply)	$40 co-payment (waived if admitted)	Participating Provider: $20 co-payment Non-Participating Provider: $100 co-payment Waived if admitted. If you receive services in addition to urgent care, additional co-payments or co-insurance may apply.	$20 co-payment per visit

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Routine Health Exams Preventative Health Care		No charge (deductible does not apply)	No charge	$20 co-payment $40 co-payment for Specialist Office Visit	No co-payment (Preventive Care Services)
Vision	• Kaiser, Health Net, UnitedHealthcare and Health Plan of Nevada cover exam only • Additional vision benefits available through either Vision Service Plan (VSP) or Spectera/UnitedHealthcare for additional premium amount • VSP Customer Service (800) 877-7195 • Spectera/UnitedHealthcare Customer Service (800) 638-3120	**Kaiser** Exam: No charge **VSP** Exam and glasses (lenses and frames) or contact lenses are available every 12 months Exam: $25 co-payment Glasses/Contact Lenses: $150 allowance **Spectera/UnitedHealthcare** Exam and lenses are available every 12 months; frame is available every 24 months Exam: $10 co-payment each for exam and materials Glasses/Contact Lenses: $130 allowance ($105 for contacts)	**Health Net** Exam: $40 co-payment Open Access: $60 co-payment **VSP** Exam and glasses (lenses and frames) or contact lenses are available every 12 months Exam: $25 co-payment Glasses/Contact Lenses: $150 allowance **Spectera/UnitedHealthcare** Exam and lenses are available every 12 months; frame is available every 24 months Exam: $10 co-payment each for exam and materials Glasses/Contact Lenses: $130 allowance ($105 for contacts)	**UnitedHealthcare** Exam: $40 co-payment Open Access: $60 co-payment **VSP** Exam and glasses (lenses and frames) or contact lenses are available every 12 months Exam: $25 co-payment Glasses/Contact Lenses: $150 allowance **Spectera/UnitedHealthcare** Exam and lenses are available every 12 months; frame is available every 24 months Exam: $10 co-payment each for exam and materials Glasses/Contact Lenses: $130 allowance ($105 for contacts)	**Health Plan of Nevada** Exam: $10 co-payment **VSP** Exam and glasses (lenses and frames) or contact lenses are available every 12 months Exam: $25 co-payment Glasses/Contact Lenses: $150 allowance **Spectera/UnitedHealthcare** Exam and lenses are available every 12 months; frame is available every 24 months Exam: $10 co-payment each for exam and materials Glasses/Contact Lenses: $130 allowance ($105 for contacts)

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		Kaiser Permanente Senior Advantage HMO	**Health Net Seniority Plus HMO**	**UnitedHealthcare Medicare Advantage HMO**	**UnitedHealthCare HMO**
Deductible The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits		Not Applicable	Not Applicable	Not Applicable	Not Applicable
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.	Individual: $1,500 Family: $3,000	$3,400 per person	$2,500 per person	$1,800 per person
Lifetime Maximum The Lifetime Maximum is the most your health plan will pay towards your healthcare costs during your lifetime.		Not Applicable	Not Applicable	Not Applicable	Not Applicable
Hospital Services Inpatient		No co-payment	No co-payment	No co-payment	$100 co-payment per admit

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		Kaiser Permanente Senior Advantage HMO	**Health Net Seniority Plus HMO**	**UnitedHealthcare Medicare Advantage HMO**	**UnitedHealthCare HMO**
Physician Office Visits and Physician Home Visits		**Office Visit** $10 co-payment **Home Visit** No co-payment	$10 co-payment	No co-payment	**Primary Care** $5 co-payment **Specialist** $20 co-payment
Telehealth (Virtual Visits)		No co-payment	$10 co-payment	No co-payment	**Primary Care** No co-payment **Specialist** $20 co-payment
Allergy Services		**Office Visits/Testing** $10 co-payment for office visits, no co-payment for testing **Treatment and Serum** $3 co-payment per injection	**Office Visits/Testing** $10 co-payment for office visits, no co-payment for testing **Treatment and Serum** No co-payment	**Office Visits/Testing** No co-payment for office visits and testing **Treatment and Serum** Cover Medicare covered treatment	**Office Visits/Testing** $5 co-payment for office visits, no co-payment for testing **Treatment and Serum** No co-payment
Ambulance Services (Ground vehicle emergency transportation)		No co-payment if medically necessary	No co-payment	No co-payment	$50 co-payment

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		Kaiser Permanente Senior Advantage HMO	**Health Net Seniority Plus HMO**	**UnitedHealthcare Medicare Advantage HMO**	**UnitedHealthCare HMO**
Chiropractic and Acupuncture Services Combined		**Chiropractic** Not covered **Acupuncture** $10 co-payment ; covered as an alternative to standard treatment when prescribed by a Plan physician; primarily used as a component of a multidisciplinary pain management program	**Chiropractic** $5 co-payment, limited to 20 visits per calendar year **Acupuncture** Not covered	**Chiropractic** No co-payment, services limited to manual manipulation of the spine to correct subluxation **Acupuncture** No co-payment, Medicare-covered acupuncture	**Chiropractic** 50% member coinsurance, services limited to manual manipulation of the spine to correct subluxation **Acupuncture** 50% co-payment, Medicare-covered acupuncture

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		Kaiser Permanente Senior Advantage HMO	**Health Net Seniority Plus HMO**	**UnitedHealthcare Medicare Advantage HMO**	**UnitedHealthCare HMO**
Prescription Drugs	• For Health Net Seniority Plus and UnitedHealthcare enrollees, prescription drug coverage is provided under the Employer Group Waiver Plan (EGWP) through UnitedHealthcare.	**Retail 30-day Supply** Generic Formulary - $10 co-payment Formulary Brand Name - $20 co-payment Non-Formulary Brand Name or Generic - Not Applicable **Mail Order 90-day Supply** Generic Formulary - $20 co-payment Formulary Brand Name - $40 co-payment Non-Formulary Brand Name or Generic - Not Applicable	**Retail 30-day Supply** Generic Formulary - $10 co-payment Formulary Brand Name - $20 co-payment Non-Formulary Brand Name or Generic - $40 co-payment Specialty Drug - $20% up to $200 **Mail Order 90-day Supply** Generic Formulary - $20 co-payment Formulary Brand Name - $40 co-payment Non-Formulary Brand Name or Generic - $80 co-payment Specialty Drug - $20% up to $200 Provided under UnitedHealthcare EGWP. Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)	**Retail 30-day Supply** Preferred/Non-Preferred Generic - No co-payment / $6 co-payment Preferred Brand Name - $35 co-payment Non- Preferred Brand Name -$60 co-payment Specialty Drug – 33% **Mail Order 100-day Supply** Preferred/Non-Preferred Generic - No co-payment / $6 co-payment Preferred Brand Name - $35 co-payment Non-Preferred Brand Name - $60 co-payment Specialty Drug - 33% Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)	**Retail 30-day Supply** Generic Formulary - $10 co-payment Preferred Brand Name - $20 co-payment Non-Preferred Brand Name - $40 co-payment Specialty Drug - $20% up to $200 **Mail Order 90-day Supply** Generic Formulary - $20 co-payment Preferred Brand Name - $40 co-payment Non-Preferred Brand Name - $80 co-payment Specialty Drug - $20% up to $400 Provided under UnitedHealthcare EGWP. Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)

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		Kaiser Permanente Senior Advantage HMO	**Health Net Seniority Plus HMO**	**UnitedHealthcare Medicare Advantage HMO**	**UnitedHealthCare HMO**
Emergency Room and Physician Charges		**Northern California** $35 co-payment **Southern California** $20 co-payment	$20 co-payment	$25 co-payment (waived if admitted)	$50 co-payment
Home Health Care		No co-payment for part time intermittent care when prescribed by a Plan physician	No co-payment	No co-payment	No co-payment per Medicare guidelines
Hospice		No co-payment	Covered under Medicare	Covered under Medicare	Covered under Medicare
Hearing Care	**Fee-for-Service Hearing Aids** • 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. • Allowed amount does not apply towards your out-of-pocket maximum. • Replacement batteries are not covered.	**Kaiser** $10 co-payment for exam **Fee-for-Service Hearing Aids** No charge of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Health Net** $10 co-payment for exam **Fee-for-Service Hearing Aids** No charge of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**UnitedHealthcare** No co-payment for exam; limited to one exam every 12 months $300 allowance every year for hearing aids **Fee-for-Service Hearing Aids** No charge of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**UnitedHealthCare** No co-payment for routine exam $20 co-payment for Medicare-covered exam $500 allowance every 3 years for hearing aids **Fee-for-Service Hearing Aids** As an additional benefit, 100% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply

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		Kaiser Permanente Senior Advantage HMO	**Health Net Seniority Plus HMO**	**UnitedHealthcare Medicare Advantage HMO**	**UnitedHealthCare HMO**
Medical Supplies, Orthopedic Braces, Prosthetic Appliances		No co-payment	No co-payment	20% member coinsurance	20% member coinsurance
Mental Health Treatment		**Inpatient** No co-payment **Outpatient** $10 co-payment	**Inpatient** No co-payment and no lifetime maximum **Outpatient** $10 co-payment, unlimited visits per calendar year	**Inpatient** No co-payment per admit limited to 190 days per lifetime **Outpatient** $15 co-payment	**Inpatient** $100 co-payment per admit limited to 190-days per lifetime **Outpatient** Individual: $20 co-payment; Group: $5 co-payment
Outpatient Surgery		$10 co-payment	No co-payment	No co-payment	$50 co-payment
Physical Therapy and Respiratory Therapy, Combined		$10 co-payment, limitations apply.	No co-payment, limitations apply.	$15 co-payment	No co-payment
Podiatry Exam		**Office Visits** $10 co-payment, must be medically necessary **Orthotic Appliances** Per Medicare guidelines	**Office Visits** $10 co-payment, must be medically necessary **Orthotic Appliances** Covered only if incorporated into a cast, splint, brace or strapping of foot	**Office Visits** No co-payment for each routine podiatry visit up to 6 visits each year **Orthotic Appliances** 20% coinsurance for each Medicare covered prosthetic or orthotic device	**Office Visits** $20 co-payment Routine podiatry limited to 6 visits per year **Orthotic Appliances** 20% coinsurance
X-Ray and Lab		No co-payment	No co-payment	No co-payment	No co-payment

MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	**Explanations and Limitations**	**Medicare Retirees Residing in California**		**Medicare Retirees Residing in Nevada**	**Medicare Retirees Residing in Arizona, California or Nevada**
		Kaiser Permanente Senior Advantage HMO	**Health Net Seniority Plus HMO**	**UnitedHealthcare Medicare Advantage HMO**	**UnitedHealthCare HMO**
Skilled Nursing Facility (SNF)		No co-payment, limited to 100 days per benefit period	No co-payment, limited to 100 days per benefit period (duration of illness) in a Medicare certified bed	Days 1-20: No co-payment Date 21-100: $25 co-payment	Days 1-20: No co-payment Date 21-100: $25 co-payment
Speech Therapy and Occupational Therapy combined		$10 co-payment, limitations apply.	No co-payment, limitations apply.	$15 co-payment	No co-payment
Substance Abuse Treatment		**Inpatient** No co-payment, detoxification only **Transitional Recovery Services** No co-payment up to a maximum of 60-days per calendar year and no more than 120 days in any 5 consecutive years in an approved non-residential facility **Outpatient** Individual: $10 co-payment; Group: $5 co-payment	**Inpatient** No co-payment, acute medical conditions only **Outpatient** $10 co-payment, unlimited visits per calendar year	**Inpatient** No co-payment **Outpatient** $15 co-payment	**Inpatient** $100 co-payment per admit **Outpatient** Individual: $20 co-payment; Group: $5 co-payment
Urgent Care		$10 co-payment	$20 co-payment	$15 co-payment	$35 co-payment
Routine Health Exams Preventative Health Care		No co-payment	No co-payment $10 co-payment for annual routine physical exam	No co-payment	No co-payment

MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	**Explanations and Limitations**	**Medicare Retirees Residing in California**		**Medicare Retirees Residing in Nevada**	**Medicare Retirees Residing in Arizona, California or Nevada**
		Kaiser Permanente Senior Advantage HMO	**Health Net Seniority Plus HMO**	**UnitedHealthcare Medicare Advantage HMO**	**UnitedHealthCare HMO**
Vision	• Kaiser, Health Net and UnitedHealthcare cover exam only • Additional vision benefits available through either Vision Service Plan (VSP) or Spectera/UnitedHealthcare for additional premium amount • VSP Customer Service: (800) 877-7195 • Spectera/UnitedHealthcare Customer Service: (800) 638-3120	**Kaiser** Exam: $10 co-payment Glasses/Contact Lenses: $175 allowance for every 24 months **VSP** Exam and glasses (lenses and frames) or contact lenses are available every 12 months Exam: $25 co-payment Glasses/Contact Lenses: $150 allowance **Spectera/UnitedHealthcare** Exam and lenses are available every 12 months; frame is available every 24 months Exam: $10 co-payment each for exam and materials Glasses/Contact Lenses: $130 allowance ($105 for contacts)	**Health Net** Exam: $10 co-payment Glasses/Contact Lenses: $100 allowance for every 24 months **VSP** Exam and glasses (lenses and frames) or contact lenses are available every 12 months Exam: $25 co-payment Glasses/Contact Lenses: $150 allowance **Spectera/UnitedHealthcare** Exam and lenses are available every 12 months; frame is available every 24 months Exam: $10 co-payment each for exam and materials Glasses/Contact Lenses: $130 allowance ($105 for contacts)	**UnitedHealthcare** Exam: No co-payment **VSP** Exam and glasses (lenses and frames) or contact lenses are available every 12 months Exam: $25 co-payment Glasses/Contact Lenses: $150 allowance **Spectera/UnitedHealthcare** Exam and lenses are available every 12 months; frame is available every 24 months Exam: $10 co-payment each for exam and materials Glasses/Contact Lenses: $130 allowance ($105 for contacts)	**UnitedHealthcare** Exam: $20 co-payment (includes glaucoma testing) No co-payment for one pair of Medicare covered standard glasses or contact lenses after a cataract surgery **VSP** Exam and glasses (lenses and frames) or contact lenses are available every 12 months Exam: $25 co-payment Glasses/Contact Lenses: $150 allowance **Spectera/UnitedHealthcare** Exam and lenses are available every 12 months; frame is available every 24 months Exam: $10 co-payment each for exam and materials Glasses/Contact Lenses: $130 allowance ($105 for contacts)

DENTAL BENEFITS FOR NON-MEDICARE AND MEDICARE RETIREES RESIDING IN ARIZONA			
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Sun Life Financial 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 Sun Life Financial HMO Dental Provider. **Sun Life Financial 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.	No Maximum	No Maximum

DENTAL BENEFITS FOR NON-MEDICARE AND MEDICARE RETIREES RESIDING IN ARIZONA			
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Sun Life Financial HMO Dental Plan**
Diagnostic, Preventative, Basic and Major 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 Members must receive all services from their assigned DeltaCare USA provider.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information
Orthodontia	Plan pays 50% of Delta Dental PPO contracted fees up to a lifetime maximum of $1,000 for dependent children only	Ortho Extractions: $0-$90 co-payment Enrollee co-payment: • Comprehensive Adult Treatment: $1,900 • Comprehensive Child Treatment: $1,700 Orthodontic Takeover: Covered	Members receive a 25% discount from the Orthodontist

DENTAL BENEFITS FOR NON-MEDICARE AND MEDICARE RETIREES 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 (866) 249-2382**	Participants must use an authorized United Concordia HMO Dental Provider. **United Concordia 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	No Maximum	No Maximum	No Maximum

DENTAL BENEFITS FOR NON-MEDICARE AND MEDICARE RETIREES 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. Members must receive all services from their assigned DeltaCare USA provider.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information.	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 NON-MEDICARE AND MEDICARE RETIREES 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. Members must receive all services from their assigned DeltaCare USA provider.
Orthodontia	Plan pays 50% of Delta Dental PPO contracted fees up to a lifetime maximum of $1,000 for dependent children only.	Ortho Extractions: $0-$90 co-payment Enrollee co-payment: • Comprehensive Adult Treatment: $1,900 • Comprehensive Child Treatment: $1,700 Orthodontic Takeover: Covered