California Ironworkers Field Welfare Plan 1/1/2018 Open Enrollment Benefit Plan Comparison
Retirees in Self-Funded Plans

NON-MEDICARE RETIREE 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**	**Participants Residing in Arizona**		**Participants Residing in California**		**Participants Residing in Nevada or Residing Outside of CA, AZ, or NV**	
		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. • **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 $750 Family Does not apply to hearing exam, hearing aids, hospice, and prescription drugs.	$500 individual $1,500 Family Does not apply to hearing exam, hearing aids, hospice, and prescription drugs. In addition, balance billing and excluded services do not count toward either deductible	$250 individual $750 Family Does not apply to hearing exam, hearing aids, hospice, and prescription drugs.	$500 individual $1,500 Family Does not apply to hearing exam, hearing aids, hospice, and prescription drugs. In addition, balance billing and excluded services do not count toward either deductible.	$250 individual $750 Family Does not apply to hearing exam, hearing aids, hospice, and prescription drugs.	$500 individual $1,500 Family Does not apply to hearing exam, hearing aids, hospice, and prescription drugs. In addition, balance billing and excluded services do not count toward either deductible.

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		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 individuals 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 include: 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.	$2,000 Individual $6,000 Family	Unlimited	$2,000 Individual $6,000 Family	Unlimited	$2,000 Individual $6,000 Family	Unlimited
Lifetime Maximum The Lifetime Maximum is the most your health plan will pay towards your healthcare costs during your lifetime.		$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000

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		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Hospital Services Inpatient	• 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.	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Physician Office Visits and Physician Home Visits		80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Allergy Services		80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Ambulance Services (Ground vehicle emergency transportation)		80% after a $50 co-payment.	80% after a $50 co-payment.	80% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible
Chemotherapy or Radiation	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271.	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Chiropractic and Acupuncture Services Combined	• Limited to a $2,000 combined annual limit for all Contracted and Non-Contracted providers.	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible

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		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Prescription Drugs through OptumRx		**Retail 30-day Supply** **Generic Formulary / Specialty Drug** $10 co-payment **Formulary Brand Name / Specialty Drug** $20 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** $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. Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)					
Emergency Room and Physician Charges	• 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.	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible

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		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Family Planning	• Services for treatment of infertility are **not covered**. • Reversal of a tubal ligation or vasectomy is not covered.	**Contraceptive Devices, and Tubal Ligation** 80% after Deductible **Vasectomy and Elective Abortions** 80% after Deductible	**Contraceptive Devices, and Tubal Ligation** 60% after Deductible **Vasectomy and Elective Abortions** 60% after Deductible	**Contraceptive Devices, and Tubal Ligation** 80% after Deductible **Vasectomy and Elective Abortions** 80% after Deductible	**Contraceptive Devices, and Tubal Ligation** 60% after Deductible **Vasectomy and Elective Abortions** 60% after Deductible	**Contraceptive Devices, and Tubal Ligation** 80% after Deductible **Vasectomy and Elective Abortions** 80% after Deductible	**Contraceptive Devices, and Tubal Ligation** 60% after Deductible **Vasectomy and Elective Abortions** 60% after Deductible
Hearing Care	• 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.	**Exam** 100% of Contract Rate up to a maximum benefit of $100 per calendar year. Deductible does not apply. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam** 100% of Allowed Charges up to a maximum benefit of $100 per calendar year. Deductible does not apply. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam** 100% of Contract Rate up to a maximum benefit of $100 per calendar year. Deductible does not apply. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam** 100% of Allowed Charges up to a maximum benefit of $100 per calendar year. Deductible does not apply. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam** 100% of Contract Rate up to a maximum benefit of $100 per calendar year. Deductible does not apply. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam** 100% of Allowed Charges up to a maximum benefit of $100 per calendar year. Deductible does not apply. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply
Home Health Care		80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Hospice		100%, Deductible does not apply	100%, Deductible does not apply	100%, Deductible does not apply	100%, Deductible does not apply	100%, Deductible does not apply	100%, Deductible does not apply

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		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	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Medical Supplies, Orthopedic Braces, Prosthetic Appliances	• 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.	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Mental Health Treatment		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Outpatient Surgery	• Non-contract ambulatory surgical centers are limited to a maximum benefit of $350 per day. • Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271.	80% after Deductible	60% after Deductible.	80% after Deductible	60% after Deductible.	80% after Deductible	60% after Deductible.
Physical Therapy and Respiratory Therapy, Combined	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271.	80% up to a maximum benefit of $2,000 per calendar year, deductible applies.	60% up to a maximum benefit of $2,000 per calendar year, deductible applies.	80% up to a maximum benefit of $2,000 per calendar year, deductible applies.	60% up to a maximum benefit of $2,000 per calendar year, deductible applies.	80% up to a maximum benefit of $2,000 per calendar year, deductible applies.	60% up to a maximum benefit of $2,000 per calendar year, deductible applies.

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		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Podiatry Exam		**Office Visits** 80% after Deductible **Orthotic appliances** Not covered	**Office Visits** 60% after Deductible **Orthotic appliances** Not covered	**Office Visits** 80% after Deductible **Orthotic appliances** Not covered	**Office Visits** 60% after Deductible **Orthotic appliances** Not covered	**Office Visits** 80% after Deductible **Orthotic appliances** Not covered	**Office Visits** 60% after Deductible **Orthotic appliances** Not covered
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	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Radiology, X-ray (Non-Complex Services) in office or facilities other than Hospital	• X-rays performed outside of your Physician's office require pre-authorization by calling Pacific Heath Alliance (PHA) Care Counseling Service.	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Skilled Nursing Facility (SNF)	• Participant payments for SNF do not accumulate to the annual Out-of-Pocket maximum	45% after Deductible up to 55 days per disability	35% after Deductible up to 55 days per disability	45% after Deductible up to 55 days per disability	35% after Deductible up to 55 days per disability	45% after Deductible up to 55 days per disability	35% after Deductible up to 55 days per disability

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		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Speech Therapy and Occupational Therapy combined	• Only covered if the case manager determines that speech/occupational therapy is medically necessary. • Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	80% up to a maximum benefit of $2,000 per calendar year.	60% up to a maximum benefit of $2,000 per calendar year.	80% up to a maximum benefit of $2,000 per calendar year.	60% up to a maximum benefit of $2,000 per calendar year.	80% up to a maximum benefit of $2,000 per calendar year.	60% up to a maximum benefit of $2,000 per calendar year.
Substance Abuse Treatment		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Supplemental Accident Coverage	• 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.	Not Applicable	100%, Deductible does not apply up to maximum payments. Remaining covered charges are subject to normal Plan provisions for Non-Contract claims.	Not Applicable	100%, Deductible does not apply up to maximum payments. Remaining covered charges are subject to normal Plan provisions for Non-Contract claims.	Not Applicable	100%, Deductible does not apply up to maximum payments. Remaining covered charges are subject to normal Plan provisions for Non-Contract claims.
Urgent Care		80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible

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		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Routine Health Exams Preventative Health Care	• Charges applied to the $300 calendar year maximum are the combined total of PPO and Non-PPO charges for routine preventive health care. Charges for immunizations are included in routine preventive care.	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible	80% after Deductible	60% after Deductible
Vision Service Plan (VSP)	• Exams, lenses and frames (or contact lenses) are available every 12 months (2nd pair of glasses available to Employee only with additional $25 materials co-payments). • VSP Customer Service: (800) 877-7195	**Exams** $25 co-payment **Frames (or Contact Lenses)** $150 allowance	)VSP and Spectera provide limited reimbursement, according to a schedule of allowances for exams and materials. Please contact your vision plan for more information.	**Exams** $25 co-payment **Frames (or Contact Lenses)** $150 allowance	VSP and Spectera provide limited reimbursement, according to a schedule of allowances for exams and materials. Please contact your vision plan for more information.	**Exams** $25 co-payment **Frames (or Contact Lenses)** $150 allowance	VSP and Spectera provide limited reimbursement, according to a schedule of allowances for exams and materials. Please contact your vision plan for more information.
Spectera/UnitedHealthcare Vision	• Exams and lenses are available every 12 months; frames are available every 24 months. • Spectera Customer Service: (800) 638-3120	**Exams** $10 co-payment for exam and materials **Frames (or Contract Lenses)** $130 allowance (or $105 allowance)		**Exams** $10 co-payment for exam and materials **Frames (or Contract Lenses)** $130 allowance (or $105 allowance)		**Exams** $10 co-payment for exam and materials **Frames (or Contract Lenses)** $130 allowance (or $105 allowance)	

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		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		Not Applicable	Not Applicable	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 individuals 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 include: 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.	$600 per person	$1,800 per person	$600 per person	$1,800 per person	$600 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	Not Applicable	Not Applicable

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		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Hospital Services Inpatient		$250 co-payment per admit	60% of Allowable Charges	$250 co-payment per admit	60% of Allowable Charges	$250 co-payment per admit	60% of Allowable Charges
Physician Office Visits and Physician Home Visits		90% of Allowed Amount after $20 co-payment	60% of Allowed Amount after $20 co-payment	90% of Allowed Amount after $20 co-payment	60% of Allowed Amount after $20 co-payment	90% of Allowed Amount after $20 co-payment	60% of Allowed Amount after $20 co-payment
Allergy Services		**Office Visits** 90% of Allowed Amount after $20 co-payment **Treatment and Serum** 90% of Allowed Amount	**Office Visits** 60% of Allowed Amount after $20 co-payment **Treatment and Serum** 60% of Allowed Amount	**Office Visits** 90% of Allowed Amount after $20 co-payment **Treatment and Serum** 90% of Allowed Amount	**Office Visits** 60% of Allowed Amount after $20 co-payment **Treatment and Serum** 60% of Allowed Amount	**Office Visits** 90% of Allowed Amount after $20 co-payment **Treatment and Serum** 90% of Allowed Amount	**Office Visits** 60% of Allowed Amount after $20 co-payment **Treatment and Serum** 60% of Allowed Amount
Ambulance Services (Ground vehicle emergency transportation)		90% after a $50 co-payment.	90% after a $50 co-payment.	90% after a $50 co-payment.	90% after a $50 co-payment.	90% after a $50 co-payment.	90% after a $50 co-payment.
Chiropractic and Acupuncture Services Combined		90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount

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		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Prescription Drugs • 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** $40 co-payment **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 Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)					
Emergency Room and Physician Charges	• 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.	90% of Allowed Amount after $100 co-payment (waived if admitted)	90% of Allowed Amount after $100 co-payment (waived if admitted)	90% of Allowed Amount after $100 co-payment (waived if admitted)	90% of Allowed Amount after $100 co-payment (waived if admitted)	90% of Allowed Amount after $100 co-payment (waived if admitted)	90% of Allowed Amount after $100 co-payment (waived if admitted)

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		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Hearing Care	• 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.	**Exam** 100% of Contract Rate up to a maximum benefit of $100 per calendar year. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate.	**Exam** 100% of Allowed Charges up to a maximum benefit of $100 per calendar year. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate.	**Exam** 100% of Contract Rate up to a maximum benefit of $100 per calendar year. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate.	**Exam** 100% of Allowed Charges up to a maximum benefit of $100 per calendar year. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate.	**Exam** 100% of Contract Rate up to a maximum benefit of $100 per calendar year. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate.	**Exam** 100% of Allowed Charges up to a maximum benefit of $100 per calendar year. **Hearing Aids** 100% of the lesser of $2,000 per device or the Contract Rate.
Home Health Care		90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount
Hospice		100% of Allowed Amount	100% of Allowed Amount	100% of Allowed Amount	100% of Allowed Amount	100% of Allowed Amount	100% of Allowed Amount
Medical Supplies, Orthopedic Braces, Prosthetic Appliances		90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount
Mental Health Treatment		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Outpatient Surgery	• Non-contract ambulatory surgical centers are limited to a maximum benefit of $350 per day.	90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount

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		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Physical Therapy and Respiratory Therapy, Combined		90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount
Podiatry Exam		**Office Visits** 90% after a $20 co-payment. **Orthotic appliances** 90% of Allowed Amount	**Office Visits** 60% after a $20 co-payment. **Orthotic appliances** Not covered	**Office Visits** 90% after a $20 co-payment. **Orthotic appliances** 90% of Allowed Amount	**Office Visits** 60% after a $20 co-payment. **Orthotic appliances** Not covered	**Office Visits** 90% after a $20 co-payment. **Orthotic appliances** 90% of Allowed Amount	**Office Visits** 60% after a $20 co-payment. **Orthotic appliances** Not covered
X-Ray and Lab		90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount
Skilled Nursing Facility (SNF)	• Participant payments for SNF do not accumulate to the annual Out-of-Pocket maximum	45% after Deductible up to 55 days per disability	35% after Deductible up to 55 days per disability	45% after Deductible up to 55 days per disability	35% after Deductible up to 55 days per disability	45% after Deductible up to 55 days per disability	35% after Deductible up to 55 days per disability
Speech Therapy and Occupational Therapy combined		90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount	90% of Allowed Amount	60% of Allowed Amount
Substance Abuse Treatment		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Urgent Care		90% after a $20 co-payment.	60% after a $20 co-payment.	90% after a $20 co-payment.	60% after a $20 co-payment.	90% after a $20 co-payment.	60% after a $20 co-payment.

MEDICARE RETIREE 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**	**Participants Residing in Arizona**		**Participants Residing in California**		**Participants Residing in Nevada or Residing Outside of CA, AZ, or NV**	
		Contract Provider	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**	**Contract Provider**	**Non-Contract Provider**
Routine Health Exams Preventative Health Care		100% of Allowed Amount with no maximum calendar year benefit	60% of Allowable Charges up to a maximum calendar year benefit of $300	100% of Allowed Amount with no maximum calendar year benefit	60% of Allowable Charges up to a maximum calendar year benefit of $300	100% of Allowed Amount with no maximum calendar year benefit	60% of Allowable Charges up to a maximum calendar year benefit of $300
Vision Service Plan (VSP)	• Exams, lenses and frames (or contract lenses) are available every 12 months (2nd pair of glasses available to Employee only with additional $25 materials co-payments). • VSP Customer Service: (800) 877-7195	**Exams** $25 co-payment **Frames/Contact Lenses** $150 allowance	VSP and Spectera provide limited reimbursement, according to a schedule of allowances for exams and materials. Please contact your vision plan for more information.	**Exams** $25 co-payment **Frames/Contact Lenses** $150 allowance	VSP and Spectera provide limited reimbursement, according to a schedule of allowances for exams and materials. Please contact your vision plan for more information.	**Exams** $25 co-payment **Frames/Contact Lenses** $150 allowance	VSP and Spectera provide limited reimbursement, according to a schedule of allowances for exams and materials. Please contact your vision plan for more information.
Spectera/UnitedHealthcare Vision	• Exams and lenses are available every 12 months; frames are available every 24 months. • Spectera Customer Service: (800) 638-3120	**Exams** $10 co-payment for exam and materials **Frames (or Contact Lenses)** $130 allowance (or $105 allowance)		**Exams** $10 co-payment for exam and materials **Frames (or Contact Lenses)** $130 allowance (or $105 allowance)		**Exams** $10 co-payment for exam and materials **Frames (or Contact Lenses)** $130 allowance (or $105 allowance)	

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**
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 **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**
Diagnostic, Preventative, Basic, and Majored Covered Services	**PPO Network**: 100% for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. **Premier Network**: 100% for Diagnostic & Preventative; 80% for Basic and Major services based on Delta Dental Premier contracted fees. **Out-of-Network**: 80% of Allowed Amount for Diagnostic & Preventative; 50% of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates for non-Delta Dental dentists.	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 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 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** **(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.	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**: 100% for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. **Premier Network**: 100% for Diagnostic & Preventative; 80% for Basic and Major services based on Delta Dental Premier contracted fees. **Out-of-Network**: 80% of Allowed Amount for Diagnostic & Preventative; 50% of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates for non-Delta Dental dentists.	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.	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: 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

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**: 100% for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. **Premier Network**: 100% for Diagnostic & Preventative; 80% for Basic and Major services based on Delta Dental Premier contracted fees. **Out-of-Network**: 80% of Allowed Amount for Diagnostic & Preventative; 50% of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates for non-Delta dentists.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information. 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

DENTAL BENEFITS FOR NON-MEDICARE AND MEDICARE RETIREES RESIDING OUTSIDE OF ARIZONA, CALIFORNIA, AND 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**: 100% for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. **Premier Network**: 100% for Diagnostic & Preventative; 80% for Basic and Major services based on Delta Dental Premier contracted fees. **Out-of-Network**: 80% of Allowed Amount for Diagnostic & Preventative; 50% of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates for non-Delta dentists.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information. 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