California Ironworkers Field Welfare Plan 1/1/2018 Open Enrollment Benefit Plan Comparison
Active Participants in HMO Plans

MEDICAL BENEFITS			
Benefit Description	**Explanations and Limitations**	**Kaiser Permanente HMO Actives residing in California**	**Health Plan of Nevada HMO Actives residing in Nevada**
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 accumulate to the Annual Out-of-Pocket Limit. The combined Out-of-Pocket Maximum on cost sharing (deductible and Out-of-Pocket Maximum) complies with the cost sharing limitations of the ACA.	• Participants must use either a Kaiser or Health Plan of Nevada (HPN) provider, depending on enrollment. • Services covered by non-Kaiser or non-HPN providers are not covered, except in cases of emergency. • Each family member may choose a different primary physician.	$250 individual $500 Family	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.	• Please refer to the Evidence of Coverage booklets for more information.	$2,000 Individual $4,000 Family	$6,000 Individual $12,000 Family
Hospital Services Inpatient		90% of Kaiser Allowed Charges after deductible	$500 per admission for hospital $100 per surgery for physician services
Physician Office Visits and Physician Home Visits		**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 co-payment **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 co-payment Deductible does not apply	$20 co-payment per primary care visit $40 co-payment for specialist care visit $10 co-payment per visit for Physicians Assistant $10 co-payment per visit for convenient care $10 co-payment per visit for telemedicine

MEDICAL BENEFITS			
Benefit Description	**Explanations and Limitations**	**Kaiser Permanente HMO Actives residing in California**	**Health Plan of Nevada HMO Actives residing in Nevada**
Allergy Services		**If you participate in the Reinforcing Smart Choices program – Office visit:** 100% after a $20 co-payment, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program - Office Visit:** 100% after a $50 co-payment, Deductible does not apply	$20 co-payment per visit
Ambulance Services (Ground vehicle emergency transportation)		$50 co-payment per trip, deductible does not apply.	$200 co-payment per trip
Chemotherapy or Radiation		$20 co-payment, deductible does not apply.	$20 per day co-payment in addition to office visit co-payment.
Chiropractic and Acupuncture Services Combined		**Chiropractic** $15 co-payment, deductible does not apply. Maximum of 30 visits per calendar year; Services provided by American Specialty Chiropractic **(800) 678-9133**. **Acupuncture** **If you participate in the Reinforcing Smart Choices program:** 100% after a $20 co-payment. Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program - Office Visit:** 100% after a $50 co-payment. Deductible does not apply Covered as an alternative to standard treatment only 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** $20 co-payment, maximum of 20 visits per member, per calendar year. **Acupuncture** Not covered

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Benefit Description	**Explanations and Limitations**	**Kaiser Permanente HMO Actives residing in California**	**Health Plan of Nevada HMO Actives residing in Nevada**
Prescription Drugs Deductible does not apply		**Retail 30-day Supply** **Generic Formulary** $15 co-payment **Formulary Brand Name** If you participate in the Reinforcing Smart Choices program: $30 co-payment If you do NOT participate in the Reinforcing Smart Choices program: $35 co-payment **Non-Formulary Brand Name or Generic** Not covered unless deemed medically necessary **Mail Order 31-day to 100-day Supply** **Generic Formulary** $30 co-payment **Formulary Brand Name** If you participate in the Reinforcing Smart Choices program: $60 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 deemed medically necessary.	**Retail: 30-day Supply** Tier I: $7 co-payment (Lowest 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 Coverage is restricted to HPN Formulary Drug. Mandatory Generic benefit provision. The member will pay the Covered Co-payment plus the difference between the EME of the Generic Covered drug and the EME of the brand name.
Emergency Room and Physician Charges		90% of Kaiser Allowed Charges after deductible	$200 co-payment per visit (waived if admitted)

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Benefit Description	**Explanations and Limitations**	**Kaiser Permanente HMO Actives residing in California**	**Health Plan of Nevada HMO Actives residing in Nevada**
Family Planning	• Reversal of a tubal ligation or vasectomy is not covered.	**Infertility** 50% for diagnosis and treatment. Member costs for Infertility treatment do not accumulate toward out-of-pocket limit. **Contraceptive Devices** 100% of Kaiser Allowed Charges, deductible does not apply. **Vasectomy** 90% of Kaiser Allowed Charges after deductible. **Tubal Ligation** 100% of Kaiser Allowed Charges, deductible does not apply. **Elective Abortions** 90% of Kaiser Allowed Charges after deductible.	**Infertility** $40 co-payment per visit / consultation only **Contraceptive Devices** 100% (covered under preventive services) **Vasectomy** $100 co-payment for inpatient facility (Physician Surgical Services) $50 co-payment for outpatient facility (Physician Surgical Services) **Tubal Ligation** 100% (covered under preventive services) **Elective Abortions** Not Covered.
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. • You are responsible for any charges above $2,000 per device. • Charges applied to the maximum Allowed Amount of $2,000 per hearing aid are the total of all Contract and non-Contract charges.	**Kaiser** 100% of Allowable Charges for exam. Benefit limited to one exam per calendar year. No charge. Deductible does not apply. **Fee-for-Service Hearing Aids** 90% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Health Plan of Nevada** $20 co-payment for exam No charge for hearing aids; Limited to a single purchase of a type of hearing aid, including repairs & replacement once every three years
Home Health Care		100% of Kaiser Allowed Charges, deductible does not apply. Maximum of 100 visits per calendar year.	$35 co-payment per visit for Physician/Nurse (requires pre-authorization)

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Benefit Description	**Explanations and Limitations**	**Kaiser Permanente HMO Actives residing in California**	**Health Plan of Nevada HMO Actives residing in Nevada**
Hospice		100% of Kaiser Allowed Charges deductible does not apply.	**Inpatient** $500 co-payment per admission **Inpatient Respite Services** $500 co-payment per admission **Outpatient Respite Services** $40 co-payment per visit, subject to maximum benefit Benefits are limited to a combined maximum benefit of five inpatient days or five outpatient visits per member per 90 days of Home Hospice Care.
Laboratory Services (in office or facility other than a Hospital)		100% of Kaiser Allowed Charges, deductible does not apply.	$10 co-payment for lab $25 co-payment for x-ray
Medical Supplies, Orthopedic Braces, Prosthetic Appliances		**Durable Medical Equipment** 90% of Kaiser Allowed charges; deductible does not apply (does not accumulate towards out-of-pocket limit). **Orthopedic & Prosthetics** 100% of Kaiser Allowed charges.	**Durable Medical Equipment (DME)** No charge. Purchases are limited to a single purchase of a type of DME, including repairs and replacement for every three years. **Prosthetics Devices** $750 co-payment per device. Purchases are limited to a single purchase of a type of prosthetic device, including repairs & replacement once every three years. **Medical Supplies** No charge

MEDICAL BENEFITS			
Benefit Description	**Explanations and Limitations**	**Kaiser Permanente HMO Actives residing in California**	**Health Plan of Nevada HMO Actives residing in Nevada**
Mental Health Treatment		**Inpatient** 90% of Kaiser Allowed Charges after deductible. **Outpatient** **If you participate in the Reinforcing Smart Choices program:** 100% after a $20 co-payment, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 co-payment, Deductible does not apply	**Inpatient** $500 co-payment per admission **Outpatient** $20 co-payment per visit
Outpatient Surgery - Facility		90% of Kaiser Allowed Charges after deductible.	$250 co-payment per surgery at a hospital facility $100 co-payment per surgery at an ambulatory surgical facility $150 co-payment per surgery for anesthesia
Outpatient Surgery -Physician and/or Surgeon fee		90% of Kaiser Allowed Charges after deductible.	$100 per surgery for outpatient hospital facility $50 per surgery at ambulatory surgical facility
Physical Therapy and Respiratory Therapy, Combined		**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 co-payment, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 co-payment, Deductible does not apply	**Inpatient** $300 per admission* **Outpatient** $20 co-payment per visit* * All rehab services are subject to a combined max benefit of 60 days/visits per member per calendar year

MEDICAL BENEFITS			
Benefit Description	**Explanations and Limitations**	**Kaiser Permanente HMO Actives residing in California**	**Health Plan of Nevada HMO Actives residing in Nevada**
Podiatry Exam	• Orthotic appliances are covered for the **Employee only**	**Office Visits** **If you participate in the Reinforcing Smart Choices program:** 100% after a $20 co-payment, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 co-payment, Deductible does not apply **Orthotic Appliances for Employee only** No co-payment, deductible does not apply.	**Office Visits** $40 co-payment (Referral required) **Orthotic Appliances for Employee only** $50 co-payment per device. Subject to a maximum benefit. Limited to a single purchase of a type of orthotic device, including repair & replacement once every three years.
Radiology, X-ray (Complex Services) including but not limited to MRI, PET and CAT scans		100% of Kaiser Allowed Charges, deductible does not apply.	$100 co-payment per test
Radiology, X-ray (Non-Complex Services) in office or facilities other than Hospital • Diagnostic x-rays	.	100% of Kaiser Allowed Charges, deductible does not apply.	$10 co-payment for lab $25 co-payment for x-ray
Radiology, X-ray (Non-Complex Services) at a Hospital • Diagnostic x-rays		90% of Kaiser Allowed Charges after deductible.	Included in co-payment for admission
Skilled Nursing Facility (SNF)		100% of Kaiser Allowed Charges up to a maximum benefit of 100 days per benefit period, deductible does not apply and does not accumulate to out-of-pocket maximum.	$300 co-payment per admission; waived if admitted from an acute care facility. Limited to 100 days per calendar year (per member)

MEDICAL BENEFITS			
Benefit Description	**Explanations and Limitations**	**Kaiser Permanente HMO Actives residing in California**	**Health Plan of Nevada HMO Actives residing in Nevada**
Speech Therapy and Occupational Therapy combined		**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 co-payment, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 co-payment, Deductible does not apply	**Inpatient** $300 per admission* **Outpatient** $20 co-payment per visit* * All rehab services are subject to a combined max benefit of 60 days/visits per member per calendar year
Urgent Care		**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 co-payment, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 co-payment, Deductible does not apply	$25 co-payment per visit
Substance Abuse Treatment	• Additional coverage through MHN (800) 977-7962	**Inpatient** **Kaiser**: 90% of Allowed Charges after deductible. **MHN**: 30-day limit per calendar year (combined with Alternate Levels of Care) with 2 episodes per lifetime. Detox limited to 4 episodes per lifetime **Outpatient** **Kaiser**: **If you participate in the Reinforcing Smart Choices program:** 100% after a $20 co-payment, Deductible does not apply **Kaiser**: **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 co-payment, Deductible does not apply **MHN**: No charge	**Inpatient** **HPN**: $500 co-payment per admission **MHN**: 30-day limit per calendar year (combined with Alternate Levels of Care) with 2 episodes per lifetime. Detox limited to 4 episodes per lifetime **Outpatient** **HPN**: $20 co-payment per visit **MHN**: No charge

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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 Service: (800) 977-7962	• **This plan offers up to three free EAP visits per calendar year for professional confidential counseling.** • 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.	**MHN** No charge for contract provider Not covered for non-contract provider	**MHN** No charge for contract provider Not covered for non-contract provider
Vision	• Kaiser and Health Plan of Nevada cover exam only **Self-Funded Vision through 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 **Self-Funded Vision through Spectera/ UnitedHealthcare** • Exams and lenses are available every 12 months; frames are available every 24 months. • Spectera Customer Service (800) 638-3120	**Kaiser** No charge for exam **Vision Service Plan** $25 co-payment for exams $150 allowance for lenses and frames / contact lenses **Spertera/UnitedHealthcare** $10 co-payment each for exams and materials $130 allowance for lenses and frames or $105 allowance for contact lenses	**Health Plan of Nevada** No charge for exam **Vision Service Plan** $25 co-payment for exams $150 allowance for lenses and frames / contact lenses **Spertera/UnitedHealthcare** $10 co-payment each for exams and materials $130 allowance for lenses and frames or $105 allowance for contact lenses

Vision benefits are available automatically at the same time you are enrolled in the Plan's Kaiser HMO Plan or in the Health Plan of Nevada HMO plan. Effective January 1, 2018, you will be able to "opt out" of the self-funded vision benefits (choose not to have vision coverage). Please note that if you do nothing, you (and any eligible dependents) will automatically be enrolled in vision coverage. Please contact the Trust Fund Office if you would like to drop (opt out of) vision coverage for yourself and any eligible dependents.

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.	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**: 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.	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 and a $265 co-payment for records fee

Dental benefits are available automatically at the same time you are enrolled in the Plan's Fee-for-Service medical benefits or in the Kaiser HMO plan. Effective January 1, 2018, you will be able to "opt out" of the Fee-for-Service dental benefits (choose not to have dental coverage). Please note that if you do nothing, you (and any eligible dependents) will automatically be enrolled in dental coverage. Please contact the Trust Fund Office if you would like to drop (opt out of) dental coverage for yourself and any eligible dependents.

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

DENTAL BENEFITS 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 are available automatically at the same time you are enrolled in the Plan's Fee-for-Service medical benefits or in the Health Plan of Nevada HMO plan. Effective January 1, 2018, you will be able to "opt out" of dental benefits (choose not to have dental coverage). Please note that if you do nothing, you (and any eligible dependents) will automatically be enrolled in dental coverage. Please contact the Trust Fund Office if you would like to drop (opt out of) dental coverage for yourself and any eligible dependents.