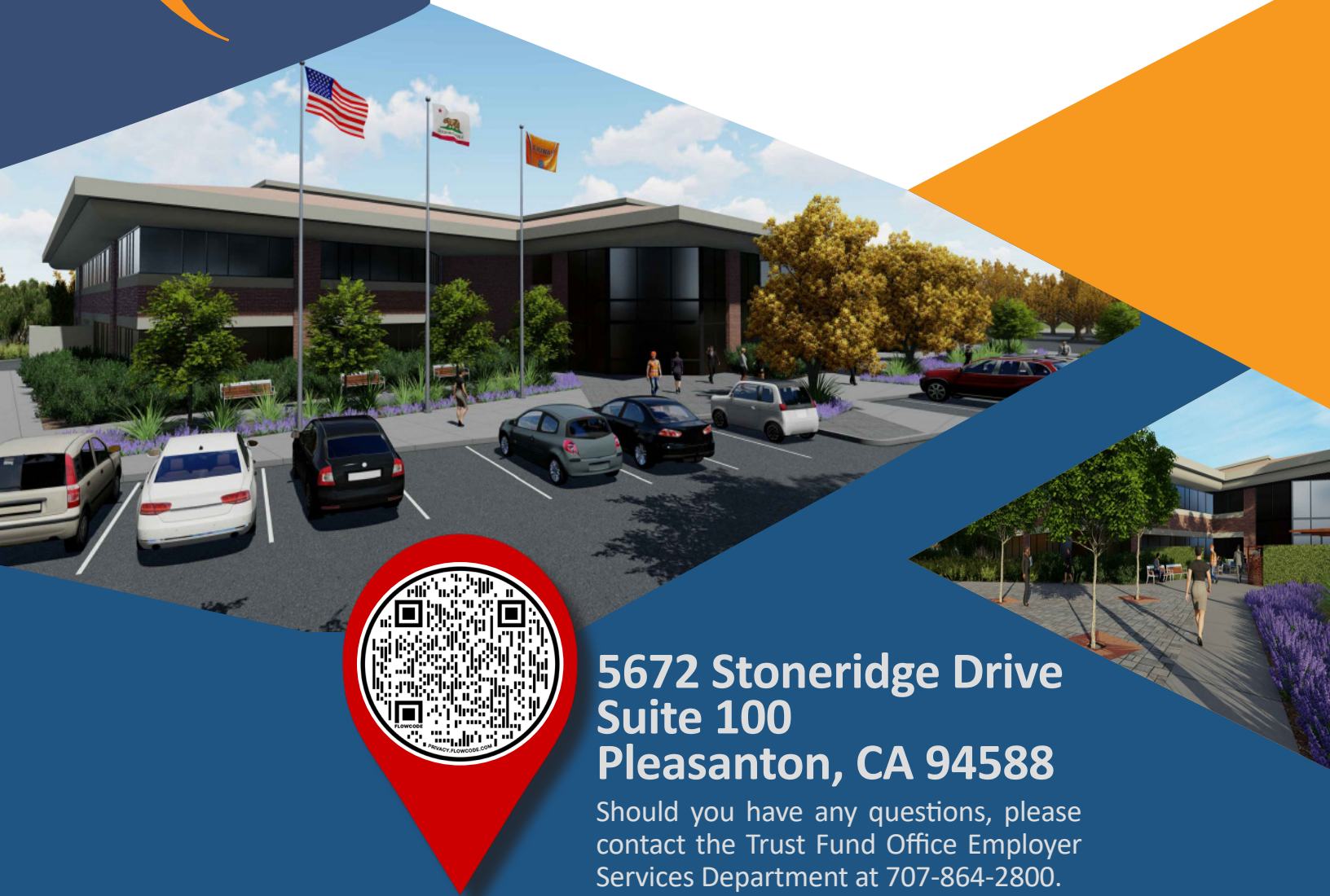




LFAO HAS MOVED TO PLEASANTON



5672 Stoneridge Drive
Suite 100
Pleasanton, CA 94588

Should you have any questions, please
contact the Trust Fund Office Employer
Services Department at 707-864-2800.

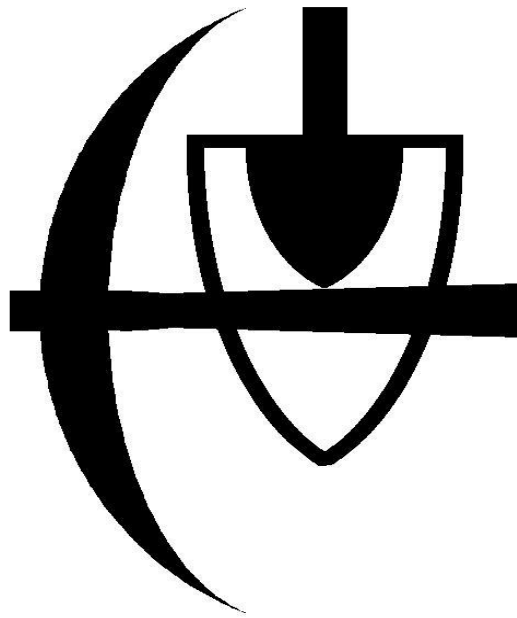
IMPORTANT REMINDER:

- Please be aware that due to the ongoing pandemic, the Trust Fund Office is **not accepting walk-ins** and only offering in-person services for Retirement related member appointments, on a **“By Appointment Only”** basis. Call 707-864-2800 to schedule an in-person Appointment for Pleasanton Office.
- Starting in October, please make sure that all documents being mailed to LFAO are sent to the new address mentioned above.

** For quick access to our new office location and directions, scan the QR code above by simply using your camera app on your Iphone or Android device. For more information visit www.LFAO.org*

**LABORERS
HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA**

ACTIVE PLAN



Summary Plan Description

June 1, 2016

For the complete Laborers Health and Welfare Plan Rules and Regulations, visit our website at www.norcalaborers.org

LABORERS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA

220 Campus Lane | Fairfield, California 94534-1498

TELEPHONE: 707-864-2800 • **TOLL-FREE NUMBER:** 800-244-4530

WEBSITE: www.norcalaborers.org

EMAIL: customerservice@norcalaborers.org

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Mr. Doyle Radford

Mr. David Gorgas

Mr. Fernando Estrada

Mr. Ramon Hernandez

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Mr. Robert Chrisp

Mr. Manuel De Santiago

Mr. Jerry Overaa

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Bullivant Houser Bailey PC

Weinberg, Roger & Rosenfeld

CONSULTANT AND ACTUARY

The Segal Company


ADMINISTRATIVE OFFICE

Laborers Funds Administrative Office of Northern California, Inc.

Byron C. Loney, Secretary

NOTICE OF GRANDFATHERED PLAN STATUS

The Plan Sponsor of the Laborers Health and Welfare Trust Fund for Northern California believes that all of the plan options offered are considered to be “**grandfathered health plans**” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the above noted plan options may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed by  mail to:

Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane
Fairfield, CA 94534



You may also contact the
Employee Benefits Security Administration, U.S. Department of Labor
at  1-866-444-3272 or  www.dol.gov/ebsa/healthreform/.
The website has a table summarizing which protections do and
do not apply to grandfathered health plans.

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Laborers Health and Welfare Trust Fund for Northern California Active Laborers Plan

Introduction

KAISER MEMBERS

Refer to your Evidence of Coverage (EOC)/Disclosures that describes the benefits, limitations and exclusions in your plan.

We are pleased to provide you with this edition of your Summary Plan Description (SPD). This SPD describes the benefits available to you through the Laborers Health and Welfare Trust Fund for Northern California effective June 1, 2016 and replaces all other plan documents previously provided to you. We hope that you will read the SPD thoroughly to familiarize yourself with the terms and provisions of your health and welfare plan. By becoming familiar with the terms of your

Plan, we believe you will save money and use your benefits wisely.

While most of the information in the SPD pertains to the **Direct Payment Plan**, other information described in the SPD applies whether you are enrolled in the Direct Payment or the optional Kaiser Permanente Plan and will be identified throughout the SPD.


This SPD describes your benefits as accurately as possible and in everyday language. It includes and explains the following sections:

- ❖ **Eligibility:** Summarizes how and when you and your Dependents become eligible for benefits.
- ❖ **Type of coverage:** Summarizes the wide range of health care benefits available to you such as medical, hospital, prescription drug, dental and vision care.
- ❖ **How and where to file claims** and, if your claim is denied, how to file an appeal for benefits.
- ❖ **General provisions:** Summarizes the type of services or expenses that are excluded or limited to a maximum benefit allowance.
- ❖ **Privacy of health information provisions:** Explains what confidential health information about you may be used and disclosed by the Trust Fund Office.
- ❖ **General information** about your rights under the Health Insurance Portability and Accountability Act (HIPAA) and Employee Retirement Income Security Act (ERISA) including a Contact Information on page 97 for the various organizations or health care providers which administer your benefits and can assist you if you have any questions.

In order to be covered for any benefits outlined in this SPD, you must be eligible at the time the covered health care services are provided. If you have questions about your benefits or how a rule may affect you or your eligible Dependents, call or write the Trust Fund Office.

The SPD is based upon the official Rules and Regulations of the Active Laborers Plan. You and your eligible Dependents have a right to have a copy of these Rules and Regulations. When a change is made to eligibility, benefits or any section in the Rules and Regulations of the Plan, you will be informed of the changes in the form of an Important Plan Benefit Change Announcement (a Summary of Material Modifications or SMM). You should retain all announcements with this SPD. Announcements can also be read, downloaded or printed from the Trust Funds' website.

RULES AND REGULATIONS

To obtain a copy of the Rules and Regulations of the Plan, you can download it from the Trust Funds'  website www.norcalaborers.org or call the Trust Fund Office.

We, the Board of Trustees ("Board") of the Laborers Health and Welfare Trust Fund, have the sole authority to resolve any questions concerning the interpretation of the provisions of the Plan described in this SPD. No employer or union, nor any of their representatives are authorized to interpret the Plan on our behalf nor can any of these entities act as our agent.

You should keep this SPD in a handy location and refer to it when you have questions about the Plan. Be sure to share this SPD with your Dependents who are also covered by the Plan.

Sincerely,

Board of Trustees

June 1, 2016

Important Information

- ❖ **Rules and Regulations of the Plan - Prevailing Authority.** In the event of any conflict between the SPD and the Rules and Regulations of the Active Laborers Plan, the official Rules and Regulations will always prevail.
- ❖ **Board of Trustees Authority.** The Board has the right to change or discontinue the eligibility rules and the types and amounts of benefits provided under this Plan.
- ❖ **Trust Fund Office Role.** The Board has authorized the Trust Fund Office to respond to your questions regarding eligibility or benefits on their behalf. You should send your written questions to the Trust Fund Office to get a formal written answer. The Trust Fund Office may also respond informally to oral questions, however, you should note that answers and information given verbally cannot be relied on in any dispute concerning your benefits and may not be binding upon the Board.
- ❖ **Gender.** Wherever any words are used in this SPD in the masculine gender, they should be considered as though they were also used in the feminine gender and vice versa.
- ❖ **Health and Welfare Trust Agreement.** The Trust Agreement provides that Individual Employers and Special Employers are only required to make payments or contributions to the cost of the operation of the Fund or of the Plan, which are contained in a collective bargaining agreement, subscriber's agreement, participation agreement or the Trust Agreement.

Online Resources



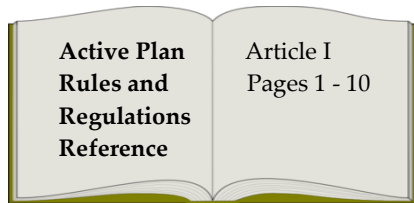
Visit the Trust Funds' website to get the latest information about your Health and Welfare Plan. You can also download or print forms, comparison of plan benefits and booklets from the website.

24/7 Member Portal - Register to access your eligibility history and benefits information. The Trust Funds' website has a direct link to the Member Portal where you can easily set-up a secure online account to gain access, 24 hours a day, 7 days a week, to your eligibility record and benefits information.



Send an email if you have any questions to:
customerservice@norcalaborers.org

Glossary of Plan Terms



The following terms are frequently used in explaining your Health and Welfare Plan.

Active Participant or Participant	Means an Employee of an Individual Employer who has established eligibility under the Plan.
Affordable Care Act (ACA)	Means the federal health care law that was enacted on March 23, 2010. Refer to page 42 for more information.
Allowed Charge; Allowed Amount; Allowable Charge	Means the maximum dollar amount that the Plan will allow for Covered Expenses. For a Preferred Provider it means the negotiated contract amount. For a Non-Preferred Provider, it means the amount established by an independent review organization retained by the Fund. Neither amount will exceed the provider's billed charges.
Ambulatory Surgical Center (ASC)	Means a licensed free-standing non-hospital based facility where surgery is performed on a same day outpatient basis.
BlueCard PPO	Means the Fund's Preferred Provider Plan network through Anthem Blue Cross outside of California but still within the United States.
Blue Distinction® Centers	Means a network of Hospitals recognized by Anthem Blue Cross for their expertise in delivering specialty care.
Board of Trustees or Board	Means a joint Board of Trustees consisting of an equal number of representatives from labor and management. The Board is responsible for the overall operation and administration of the Plan.
Coinsurance	Means the Fund and your share of the cost for a Covered Expense shown as a percentage.
Concurrent Review	Means a Utilization Review (UR) that occurs after admission to the Hospital as an inpatient and while still confined as a bed patient.
Copayment	Means an upfront amount that you pay for a Physician's or other covered provider's Office Visit, Electronic or Online Medical Evaluation, Hospital Emergency Room Visit or Prescription Drugs.
Covered Charges	Means the Non-Participating Hospitals charges for inpatient hospitalization that are covered under the Plan.

Covered Expenses	Means the type of medical services and supplies that are covered under the Plan.
Deductible	Means the amount that you pay every Plan Year before the Plan begins paying certain benefits for Covered Expenses.
Deductible Carryover Period	Means the last three months of the Plan Year, December, January and February. Any annual Deductible you paid during the carryover period will be applied to your Deductible for the next Plan Year.
Dependent	Means your lawful spouse or Domestic Partner, Your or your Domestic Partner's natural, adopted or step child or child acquired through legal guardianship or foster agency younger than age 26 (Dependent children are covered until the end of the month in which they turn age 26), Handicapped child older than age 26, if the child was eligible as a Dependent under the Plan prior to age 26, and who is prevented from earning a living because of mental or physical handicap provided the child is primarily dependent upon the Participant for support.
Eligible Individual	Means a Participant or an eligible Dependent of the Participant.
Emergency Medical Condition	Means a medical condition that without immediate medical treatment would seriously jeopardize your health.
Emergency Services	Means outpatient services at a Hospital emergency room for an Emergency Medical Condition.
Employee	Means a person who is working for an Individual Employer and for whom contributions are made to the Laborers Health and Welfare Trust Fund.
ERISA Plan Year	Means June 1 through May 31 each year. This is the Plan's fiscal accounting period and is different than the benefit Plan Year which is March 1 through February 28 of each year.
Experimental or Investigative Procedures	Means a drug, device or medical treatment or procedure if: <ul style="list-style-type: none"> a. The drug or device cannot be lawfully marketed without the approval of the <u>F</u>ood and <u>D</u>rug <u>A</u>dministration (FDA); and <ul style="list-style-type: none"> (1) Approval for marketing has not been given at the time the drug or device is prescribed or provided; or (2) Approval has not been given by the FDA for the specific diagnosis, illness or condition for which the drug or device is prescribed or provided; or

- b. The drug, device, medical treatment or procedure, or the patient's informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires a review or approval; **or**
- c. **"Reliable Evidence"** shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment or diagnosis; **or**
- d. **"Reliable Evidence"** shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

For the purpose of this Section, **"Reliable Evidence"** means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Fund	Means the Laborers Health and Welfare Trust Fund for Northern California.
Group Plan	Means any plan providing benefits of the type provided by this Plan which is supported wholly or in part by employer's payments.
Hospital	Means licensed, general acute care Hospitals that provide 24/7 care. Hospital also means licensed free-standing psychiatric treatment facilities and substance abuse treatment facilities.
Hour Bank	Means an account established for each Employee into which work hours are deposited.

Individual Employer	Means an employer who is required by a collective bargaining agreement or subscriber's agreement to contribute to the Laborers Health and Welfare Trust Fund for Northern California.
Local Union or Union	Means any local union affiliated with the Union whose members perform work covered by the Laborers 46 Northern California Counties Master Agreement.
Maximum Plan Allowance (MPA)	Means a dollar maximum allowed by the Plan for specific Covered Expenses. Refer to Allowed Charge on page 1 for more information.
Medically Necessary	Means services that are determined by the Board of Trustees as appropriate and necessary for the symptoms, diagnosis or treatment of an illness or injury, provided for the diagnosis or direct care and treatment of the illness or injury; within standards of good medical practice; not primarily for the personal comfort or convenience of the patient, the patient's family, or any caregiver, provider or facility; the most appropriate supply or level of service that can safely be provided; and are not more costly than another equally effective course of treatment, service, or sequence of services. Refer to Article I, Section 31.00 of the Rules and Regulations of the Plan for more details about the term "Medically Necessary".
Non-Participating Hospital	Means a Hospital that is not part of the Fund's Preferred Provider Plan (also known as Non-PPO).
Non-Participating Provider	Means a Physician, laboratory, radiology facility, Ambulatory Surgical Center (ASC) or other licensed health care provider that is not part of the Fund's Preferred Provider Plan (also known as Non-PPO).
Out-of-Pocket Maximum	Means a Plan Year dollar limit that you pay including Copayments, Deductible and coinsurance amounts for Covered Expenses incurred at Participating Hospitals or Providers.
Participating Hospital	Means a Hospital that is part of the Fund's Preferred Provider Plan network (also known as PPO).
Participating Provider	Means a Physician, laboratory, radiology facility, Ambulatory Surgical Center (ASC) or other licensed health care provider that is part of the Fund's Preferred Provider Plan network (also known as PPO).
Plan Year	Means the Benefit Plan Year, March 1 through February 28.

Pre-Admission Review	Means a Utilization Review (UR) for an elective admission before an Eligible Individual is admitted to a Hospital in order to determine the number of Hospital days that are Medically Necessary.
Preferred Provider Organization (PPO)	Means a managed care organization of health care providers who have an agreement to accept lower fees for their services. The agreements are between the health care providers and Anthem Blue Cross (not the Fund).
Preferred Provider Plan	Means a program or plan of benefits which uses the services of a Preferred Provider Organization (PPO) for the provision of medical services at negotiated contract rates.
Preferred Provider Plan Service Area	Means all zip codes for California Counties in which Eligible Individuals live and are subject to the reimbursement provisions of the Preferred Provider Plan. The Preferred Provider Plan Service Area also includes the BlueCard PPO national network.
Professional Review Organization (PRO)	Means the company under contract with the Fund to provide services to the Plan for Utilization Review (UR).
Retrospective Review	Means a Utilization Review (UR) that occurs after discharge from the Hospital when there has been no Pre-Admission and/or Concurrent Review.
Utilization Review (UR)	<p>Means a review that determines the number of Hospital days that are Medically Necessary for a Hospital confinement. There are three different types of Utilization Review:</p> <ol style="list-style-type: none"> 1. Pre-Admission Review—required on all elective Hospital admissions (except for certain maternity confinements). 2. Concurrent Review—any Hospital admission. 3. Retrospective Review—takes place after the patient has been discharged when there has been a failure to obtain the required Pre-Admission or Concurrent Review.
Value-Based Site	Means, for routine total single hip or single knee replacement surgery, a Designated Hospital that is part of the Fund's Preferred Provider Plan network. For outpatient arthroscopy, cataract or colonoscopy procedures, it means an Ambulatory Surgical Center (ASC) that is part of the Fund's Preferred Provider Plan network.

Health Plans Available and Options

Hospital-Medical Health Care Plans

Both the Direct Payment and Kaiser Permanente Plans offered through the Fund provide comprehensive hospital-medical and prescription Drug benefits to you and your eligible Dependents.

OPEN ENROLLMENT


There is no annual open enrollment period for medical plans. You are allowed to switch between the two medical plans anytime in a calendar year up to a maximum of two times per calendar year.


When you first become eligible, you are automatically enrolled in the Direct Payment Plan for hospital-medical and prescription Drug benefits. If you live or work within a Kaiser service area in Northern California, you may switch to Kaiser before or after you become eligible by submitting an Active Plans' Application Form. **Whichever medical plan option you choose, your Dependents must be enrolled in the same plan.**

If you are considering Kaiser as your hospital-medical plan of choice, there is a separate Evidence of Coverage EOC/Disclosures booklet explaining the benefits, limitations and exclusions of the Kaiser Permanente Plan. If you would like more information about the Kaiser Permanente Plan **before** you consider a plan change, call the Trust Fund Office to request a Kaiser Permanente Plan booklet. Otherwise a booklet will automatically be sent to you after your application for a plan change has been received and processed by the Trust Fund Office. If you have questions about the Kaiser Permanente Plan, you can also call Kaiser directly.

CONTACT INFO

Kaiser Permanente

 1-800-464-4000

 www.kaiserpermanente.org

You should carefully review the Comparison of Benefit Plans, this SPD, and if needed, the official Plan Rules and Regulations and the Kaiser Permanente Plan's EOC to see which plan will meet the health care needs of you and your eligible Dependents.

Before you change plans, you may want to consider making the change effective on the beginning of the Plan Year. This means your Application Form has to be at the Trust Fund Office no later than January 15th for a March 1st effective date.

OUT-OF-POCKET

If you switched Plans, any deductible or out-of-pocket costs that have been applied under your old plan will not count towards your deductible or out-of-pocket share required under your new plan.

When you change plans, you will be notified **in writing** confirming the effective date of the change. **Do not assume your plan has changed until you receive a letter from the Trust Fund Office confirming the effective date of your new plan.**

If you are a COBRA Qualified Beneficiary, you are allowed to switch plans the same way and same number of times in a calendar year just like Employees. Refer to page 30 for more information regarding COBRA.

Direct Payment Plan Service Area

Coverage is only provided throughout the United States, its Territories and Possessions. Covered Expenses incurred outside of the United States, its Territories and Possessions will be limited to Emergency Services as determined by the Plan.

Kaiser Permanente Plan Service Area

Coverage is only provided at Kaiser Permanente facilities throughout **Northern California**. Coverage outside of **Northern California** is limited to emergency care services only. Consult the Kaiser Permanente Evidence of Coverage/Disclosures.

Dental Care Plans

When you are eligible for hospital-medical benefits, regardless of which plan you choose, you are also eligible to participate in one of the four dental plans offered by the Fund. Whichever dental plan option you choose, your Dependents must be enrolled in the same plan.

When you first become eligible, you are automatically enrolled in the Delta Dental Plan for dental care benefits. You may elect to switch to one of the optional dental plans below by submitting an Active Plans' Dental Enrollment Form before you become eligible or **within 60 days** of first becoming eligible, otherwise you can change your dental plan only during the annual Open Enrollment (OE). After your initial choice, you are allowed to switch plans every March, the beginning of the Plan Year, by submitting a new Dental Enrollment Form.

Dental Plans Brochures

For detailed information about the dental benefits, contact the Trust Fund Office. These plans are described in separate brochures.

Dental plan options are outlined on the Comparison of Dental Plans. The plans are explained in greater detail in each of the plan's official summary of benefits, exclusions and limitations.

If, after reviewing the Comparison of Dental Plans, you would like to see more information about a specific dental plan option before you make a change, call the Trust Fund Office to request a copy of the official summary of benefits, exclusions and limitations.


If you are a COBRA Qualified Beneficiary, the Trust Fund Office will offer you the same hospital-medical, prescription Drug, dental and vision benefits you have the day before the Qualifying Event. You have an option to reject dental and vision care benefits -- the "Non-Core Benefits" -- when you first enroll for COBRA Continuation Coverage. However, you may not elect dental and vision benefits only without a hospital-medical plan.


Delta Dental of California

Delta Dental is the Fund's self-funded dental plan administered by Delta Dental of California.

CONTACT INFO

Delta Dental

 1-800-765-6003

 www.deltadentalins.com

Carefully read the Delta Dental plan brochure which contains the “Table of Allowances” (the list of covered dental services and how much the Plan will pay for each covered dental service—after your annual Deductible, where applicable) and explains the benefits, exclusions and limitations of the self-funded dental plan. **Important:** Only the dental services listed in the “Table of Allowances” are covered by the Plan. Charges that exceed the amounts listed in the Table of Allowances are your responsibility to pay in addition to any applicable Plan Year Deductible as are all charges that exceed the annual Plan Year Maximum.

If you choose to remain with Delta Dental, you have the freedom to select your own dentist. However, you may wish to consider using dentists who contract with Delta Dental under either the Delta Premier or Delta PPO networks. Dentists who participate under either of these networks have had their fees pre-approved by Delta Dental and are not permitted to bill you for any amounts over the pre-approved fees.

The difference between the “Premier” network and the “PPO” network is that the dentists in the Delta “PPO” network have agreed to accept lower fees for their services. This will save you money based on the cost of the covered dental services listed in the “Table of Allowances”.

DeltaCare USA

CONTACT INFO

DeltaCare USA



1-800-422-4234



www.deltadentalins.com

DeltaCare USA is a fully insured pre-paid Dental Health Maintenance Organization (DHMO). Under this type of plan, you must pre-select your dental office or dentist from a list of participating dental providers.

Before you decide upon this type of plan, you should very carefully read the DeltaCare USA plan brochure which contains the schedule of covered dental services and explains the benefits, exclusions and limitations of the plan. Dental services not listed in the schedule of covered dental services are not covered by the plan. Ask questions before you make a change because you cannot change to another plan until the next Open Enrollment (OE).

Under the DeltaCare USA plan, there is no annual Deductible nor is there a Plan Year maximum. Most covered dental services have set Copayments and some covered dental services have no Copayment.

UnitedHealthcare Dental

(Formerly Pacific Union Dental)

CONTACT INFO

UnitedHealthcare Dental



1-800-999-3367



www.myuhcdental.com

UnitedHealthcare Dental is a fully insured pre-paid DHMO. Under this type of plan, you can use only **“in-network”** dentists. To locate an **“in-network”** dentist, visit the UnitedHealthcare Dental website and click **“Find a Dentist”**. An **“in-network”** dentist is one that participates in the UnitedHealthcare Dental **“CA Select Managed Care Direct**

Compensation” plan. You do not need to “pre-select” a dentist, but you must always use an “in-network” dentist. Dentists are available only in California.

Before you decide to enroll in the UnitedHealthcare Dental plan, you should carefully read the official plan materials which contains the schedule of covered dental services and explains the benefits,

exclusions and limitations of the plan. Dental services not listed in the schedule of covered services are not covered by the plan. Ask questions before you make a change because you cannot change to another plan until the next Open Enrollment (OE).


Under this plan, there is no Plan Year Deductible or Plan Year maximum. Most covered dental services have set Copayments and some covered dental services have no Copayment.


Bright Now! Dental

Bright Now! Dental is a fully insured pre-paid Dental Health Maintenance Organization (DHMO). Under this type of plan, you must pre-select your dental office or dentist from a list of participating dental providers.

CONTACT INFO

Bright Now! Dental

 1-888-274-4486

 www.brightnow.com

Before you decide upon this type of plan, you should very carefully read the Bright Now! Dental plan brochure which contains the schedule of covered dental services and explains the benefits, exclusions and limitations of the plan. Dental services not listed in the schedule of covered dental services are not covered by the plan. Ask questions before you make a change because you cannot change to another plan until the next Open Enrollment (OE).

Under the Bright Now! Dental plan, there is no annual Deductible nor is there a Plan Year maximum. Most covered dental services have set Copayments and some covered dental services have no Copayment.

Open Enrollment


Open Enrollment (OE) for the dental plans begins December 1st and ends on February 15th for a March 1st effective date. The purpose of OE is to enable you to change your dental plan option.

If you are a COBRA Qualified Beneficiary who either declined enrollment in a dental plan when you were first eligible for COBRA or elected a dental plan but later cancelled the coverage, you will not be able to enroll again for a dental plan during OE.

Dental Enrollment Form

If you decide to change dental plans, either during OE or within 60 days of first becoming eligible, you must complete an Active Plans' Dental Enrollment Form. Be sure to complete the form by answering all of the questions, sign, date and then mail the completed form to the Trust Fund Office so that it is received no later than 60 days after your initial eligibility date. If you are submitting it during OE, it must be received by the Trust Fund Office before February 15th.

DENTAL ENROLLMENT FORM

To obtain a blank form, contact the Trust Fund Office or download the form from the Trust Funds'  website at www.norcalaborers.org.

When you change plans, you will be notified **in writing** confirming the effective date of the change. **Do not assume your plan has changed until you receive a letter from the Trust Fund Office confirming the effective date of your new plan.**

Comparison of Dental Plans Chart

Plan Features	Delta Dental of California	Bright Now!	United HealthCare	DeltaCare USA
<i>Type of Plan</i>	Traditional FEE-FOR-SERVICE Plan. You may select any dentist, however, your out-of-pocket costs is greater if you use a non-Delta Dental Premier dentist.	Pre-paid HMO type Plan. You select a Bright Now! dentist who provides all services including referrals to Specialists.	Pre-paid HMO type Plan. You select a United HealthCare dentist who provides all services including referrals to Specialists.	Pre-paid HMO type Plan. You select a DeltaCare USA dentist who provides all services including referrals to Specialists.
<i>Area Covered</i>	More than 9,000 Northern California Delta Dental Premier dentists.	Roseville, Modesto, Fresno, Visalia, Oakland, Daly City, Fremont, Martinez, Salinas, San Jose, Pinole, Belmont, Rohnert Park, Clovis, Sacramento.	Dental Offices throughout Northern California.	DeltaCare USA dentists throughout Northern California.
<i>Choice of Dentists</i>	Any dentist, however, you pay less out-of-pocket costs when you use a Delta Dental Premier dentist because fees are pre-negotiated and dentist cannot charge more than the pre-negotiated amount.	Bright Now! dentist only. All services and referrals must be provided by a Bright Now! dentist. No benefits will be paid if dental services are performed by other than a Bright Now! dentist.	United HealthCare dentist only. All services and referrals must be provided by a UnitedHealthCare dentist. No benefits will be paid if dental services are performed by other than a United HealthCare dentist.	DeltaCare USA dentist only. All services and referrals must be provided by a DeltaCare USA dentist. No benefits will be paid if dental services are performed by other than a DeltaCare USA dentist.
<i>Annual Deductible</i>	\$100 per person, \$300 family Diagnostic and preventative services not subject to Plan Year Deductible.	None	None	None
<i>Annual Maximum</i>	\$2,500 per person	No maximum	No maximum	No maximum
<i>Out of Pocket Costs</i>	100% payable for diagnostic and preventive services. 70% payable of allowed charge for major services.	Minimal copayments	Minimal copayments	Minimal copayments
<i>Orthodontic Benefits</i>	\$1,500 lifetime maximum per person. Coverage for member, spouse and children.	Start up fee of \$350. Member's copayment up to \$2,045. Coverage for member, spouse and children.	Start up fee of \$350. Member's copayment up to \$2,250. Coverage for member, spouse and children starting at age 10.	Start up fee of \$350. Coverage for adults is up to \$1,800 and for children is up to \$1,600.

Vision Care Plan

When you are eligible for hospital-medical benefits, regardless of which hospital-medical plan you choose, you are also eligible for vision care benefits.

If you are a COBRA Qualified Beneficiary, the Trust Fund Office will offer you the same hospital-medical, prescription Drug, dental and vision benefits you have the day before the Qualifying Event. You have an option to reject dental and vision care benefits -- the "Non-Core Benefits" -- when you first enroll for COBRA Continuation Coverage. However, you may not elect dental and vision benefits only without a hospital-medical plan.



Vision Plan Brochures

For detailed information about your vision benefits, contact the Trust Fund Office. The benefits are described in separate brochure.

Direct Payment Plan Participants

When you first become eligible, you are automatically enrolled in the Direct Payment Plan for hospital- medical plan and in the Anthem Blue Cross Blue View Vision Plan for vision care. The Fund **does not** offer other vision plans to Participants who are enrolled in the Direct Payment Plan. If you want to make a change to your vision plan, you have to switch your hospital-medical plan first to Kaiser Permanente and enroll in their Vision Essentials Plan.

CONTACT INFO

Blue View Vision
 1-866-723-0515
 www.anthem.com/ca

Kaiser Permanente Plan Participants

If you are enrolled in the Kaiser Permanente Plan when you first become eligible, you are automatically enrolled in the Kaiser Permanente Vision Essentials Plan. You may elect to switch to Anthem Blue Cross Blue View Vision Plan by submitting an Active Plans' Vision Enrollment Form before you become eligible or **within 60 days** of first becoming eligible, otherwise you can change your vision plan only during the annual Open Enrollment (OE) – see Open Enrollment below.

Open Enrollment


(Kaiser Permanente Plan Participants Only)

After your initial choice, you are allowed to switch vision plans every March, the beginning of the Plan Year, by submitting a new Vision Enrollment Form. Open Enrollment (OE) begins December 1st and ends on February 15th for a March 1st effective date. The purpose of OE is to enable you to change your vision plan option.

If you are a COBRA Qualified Beneficiary who either declined enrollment in a vision plan when you were first eligible for COBRA or elected a vision plan but later cancelled the coverage, you will not be able to enroll again for a vision plan during OE.

Vision Enrollment Form

VISION ENROLLMENT FORM

To obtain a blank form, contact the Trust Fund Office or download the form from the Trust Funds'  website at www.norcalaborers.org.

If you decide to change vision plans, either during OE or within 60 days of first becoming eligible, you must complete a Vision Enrollment Form. Be sure to complete the form by answering all of the questions, sign, date and then mail the completed form to the Trust Fund Office so that it is received no later than 60 days after your initial eligibility date.

When you change plans, you will be notified **in writing** confirming the effective date of the change. **Do not assume your plan has changed until you receive a letter from the Trust Fund Office confirming the effective date of your new plan.**

Anthem Blue Cross Blue View Vision Benefit Chart

When you use a Blue View Vision provider, you will be entitled to discounts on charges for some non-covered items by the Plan.

Covered Benefit and Frequency Limitation	IN-NETWORK PROVIDER		NON-NETWORK PROVIDER
	Plan Allowance	Your Copay	
Routine Eye Exam <i>Every 12 months</i>	Covered in full	\$10	\$37 allowance only
Eyeglass Frame <i>Every 24 months</i>	\$145	You pay the balance after \$145 allowance less 20% discount	\$40 allowance only
Eyeglass Standard Lenses <i>Every 12 months</i> 1 pair only of Single, Bifocal, Trifocal or Lenticular lenses	Covered in full	\$20 (1 pair limit)	\$34 to \$68 allowance only depending on type of lenses
Contact Lenses (Conventional) <i>Every 12 months</i>	\$120	You pay the balance after \$120 allowance less 15% discount	\$100 allowance only

Kaiser Vision Essentials Benefit Chart

Covered Benefit and Frequency Limitation	AT KAISER PERMANENTE OPTICAL CENTERS		
	Plan Allowance	Your Copay	Notes
Routine Eye Exam <i>No limit</i>	Covered in full	\$15	No copayment for preventive screenings
Eyeglass Frame <i>Every 24 months</i>	\$145	You pay the balance after \$145 allowance	Fashionable frames priced between \$40 to \$99
Eyeglass Standard Lenses <i>Every 12 months</i>	Covered in full		1 pair only of clear plastic, single, flat-top multifocal or lenticular lenses
Contact Lenses (Conventional) <i>Every 12 months</i>	\$120	You pay the balance after \$120 allowance	Order refills online at kp2020.org/noca

Important Plan Benefit Change Announcements

When there is a change to the Direct Payment or Kaiser Permanente Plan, one of the dental plans or one of the vision plans which is considered a “material modification to the Plan”, you will be notified prior to the effective date of the change. However, not all changes are considered material modifications. A material modification is generally a major or a significant change in benefits or Plan rules and will result in amendments to the Plans, Evidence of Coverage or other benefit summaries.

What Are “Self-Funded” Plans

Self-funded plans are ones in which the Fund assumes the financial risk for providing Plan benefits to Eligible Individuals. The Fund’s self-funded plans are the:

- Direct Payment Plan (including prescription drugs)
- Delta Dental of California
- Anthem Blue Cross’ Blue View Vision

In order to carry out some of the self-funded administrative duties, the Fund has contracts with various other companies such as Anthem Blue Cross (ABC), Delta Dental of California and OptumRx. The Fund pays a monthly fee to each of these companies to perform certain administrative duties on behalf of the Fund.

What Are “Fully Insured” Plans

A fully insured plan is one for which the Fund pays a monthly premium to a plan and the plan assumes the financial risk for providing benefits to Eligible Individuals, such as the Kaiser Permanente Plan, DeltaCare USA, Bright Now! Dental and UnitedHealthcare Dental. In addition, fully insured plans must include state mandated benefits.

All benefits, whether self-funded or fully insured, are primarily paid for from the contributions made to the Fund by Individual Employers who are signatory to a collective bargaining agreement or subscriber's agreement between the Union and the employer groups.

Grievance Procedures for Dental and Vision Plans


Delta Dental of California, DeltaCare USA, UnitedHealthcare Dental, Bright Now! Dental and Anthem Blue Cross Blue View Vision have grievance procedures for handling complaints. If you have a complaint with one of these companies, you should first seek resolution using the company's complaint procedure before appealing to the Board of Trustees of the Laborers Health and Welfare Trust Fund for Northern California. If, however, the complaint involves your eligibility under the Plan, contact the Trust Fund Office.

Overview of Plan Options

Hospital-Medical and Prescription Drugs	Dental Care	Vision Care
Direct Payment Plan (The default medical plan at initial eligibility unless you switched to Kaiser Permanente beforehand)	Delta Dental of California (The default dental plan at initial eligibility unless you switched to another dental plan below beforehand)	Anthem Blue Cross Blue View Vision (BVV) (The default and only vision plan for Participants enrolled in Direct Payment Plan at initial eligibility)
Kaiser Permanente Available only if you live within a Kaiser service area in Northern California	DeltaCare USA Bright Now! Dental UnitedHealthcare Dental	Kaiser Vision Essentials (The default vision plan for Participants enrolled in Kaiser Permanente at initial eligibility)
You can switch plans up to two times per calendar year	You can switch plans at the beginning of the Plan Year only (March 1)	Kaiser Permanente Participants only You can switch between Blue View Vision and Kaiser Vision Essentials at the beginning of the Plan Year only (March 1)
All family members must enroll in the same plan	All family members must enroll in the same plan	All family members must enroll in the same plan

Enrollment in the Plan

Enrollment Form

All Participants working for a Contributing Employer are required to complete and send an Enrollment Form to the Trust Fund Office. The information on your Enrollment Form is very important and the source used by the Trust Fund Office to identify you and where to send informational materials to you. You should file an Enrollment Form immediately after you start performing work for a Contributing Employer -- you do not have to wait until you become eligible for benefits. Blank Enrollment Forms are available at your Local Union, the Trust Fund Office or you may download a copy from the Trust Funds'  website at www.norcalaborers.org. Not filing an Enrollment Form may also cause a delay in the processing of your claims.

The Enrollment Form is also the means by which you list your covered Dependents and designate your beneficiary for Death Benefits. In order for your Dependents to be eligible for benefits, you must list them on the Enrollment Form **and** provide the Trust Fund Office the required documents to verify your relationship with your Dependents.

INFORMATION REQUIRED

Federal law requires group health plans to obtain social security numbers of any person enrolled in their plan. The eligibility of your Dependents may be suspended or terminated if you do not provide the information required.

If you have already submitted an Enrollment Form to the Trust Fund Office and supplied the required documents to enroll your Dependents, you may wish to contact the Trust Fund Office to confirm that your Dependents are properly enrolled.

Keep the Trust Fund Office Informed of Changes

When any change occurs in the information you provided on the Enrollment Form, you should notify the Trust Fund Office immediately by submitting a new Enrollment Form. Examples of changes:

- Marriage (add a new spouse and, if any, new stepchildren)
- Divorce or separation (delete a former spouse and, if any, stepchildren)
- Birth or adoption of a child (add a new child)
- Death of a Dependent
- Add or change your beneficiary designation
- Any other change in Dependent status (such as the separation from your Domestic Partner)

New Eligible Packet

As a new Participant, the Trust Fund Office will send you a "New Eligible Packet". The packet contains an Enrollment Form, important information about the Fund's hospital-medical, dental and vision plans, the options available to you and the necessary forms **if** you wish to change medical, dental or vision plans as described in the Health Plans Available and Options section.


The packet includes the most recent "Comparison" of benefits for hospital-medical plans, dental plans and vision plans. The Comparisons are companion documents to this SPD and provide an overview of

the Plan options. The Comparisons, however, do not replace this SPD nor the official Plan Rules and Regulations for the Direct Payment Plan, the EOC/Disclosures for the Kaiser Permanente Plan or the summary of benefits, exclusions and limitations for the dental and vision plans.

Keep the Trust Fund Office Informed of Your Contact Information

IMPORTANT MESSAGE

The Trust Fund Office cannot accept a change of address over the phone.

If you need to make changes to your contact information on your Enrollment Form, you should do so by submitting a Change of Address Notification form. Blank forms are available at your Local Union, the Trust Fund Office or you may download a copy from the Trust Funds'  website at www.norcalaborers.org. If you have Dependents who live at an address separate from yours, use a separate piece of paper and write down their name, birth date, social security number and mailing address and attach it to the Change of Address Notification form.


Documents Required to Enroll Dependents

For Spouse

In order to complete the enrollment of a spouse, you must list your spouse on the Enrollment Form with her date of birth and her social security number and provide a certified copy of the marriage certificate.

CAUTION

If you do NOT remove your former spouse, including any of your former stepchildren, from your Enrollment Form and the Plan pays claims for services on or after the date they become ineligible under the Plan, YOU will be responsible for paying back the Plan the amount of benefits paid on behalf of your former dependents.

If You Divorce - As of the date your divorce becomes final, your former spouse along with any stepchildren are no longer eligible Dependents under the Plan. As soon as you know this date, you must act immediately by notifying the Trust Fund Office in writing and completing a new Enrollment Form deleting all ineligible individuals.  Mail the new Enrollment Form with a copy of your final Judgment of Dissolution terminating your marriage. You should follow-up with the Trust Fund Office within 15 business days from the date you mail these documents to the Trust Fund Office to make sure that they arrived and the individuals you asked to be removed have actually been removed from coverage.

For Domestic Partner

The Plan provides coverage for a domestic partner and the domestic partner's children, if any, but only if you work for an Individual Employer that has a job contract with a city, county or State of California that under a law or regulation requires your employer to provide domestic partner coverage.


In order to complete the enrollment of a domestic partner, you must list your Domestic Partner on the Enrollment Form with his date of birth and social security number and provide a copy of your domestic partnership certificate issued by a government agency. Your employer must also certify in writing that they are doing business with a city, county or State of California.

For Children

In order to complete the enrollment of your Dependent children, you must list each child on the Enrollment Form with their date of birth and social security number. You must also provide a copy of each child's certified birth certificate.

A Dependent child reaching the age of 26, is no longer eligible under the Plan as of the last day of the month in which the Dependent turns age 26, however, the child may choose to continue coverage under the Plan's COBRA Continuation Coverage – refer to page 30 for COBRA information.

OTHER DOCUMENTS

If you do not have a copy of your child's birth certificate,  contact the Trust Fund Office for list of other acceptable documents to enroll your child.

In order to complete the enrollment of a Dependent child who is adopted, acquired through legal guardianship or placed in your home through a foster agency, you must also provide copies of the court documents as proof of the adoption or appointing you as the legal guardian. If the child you are enrolling is a foster child, you must provide copies of the placement documents from the foster care agency.

Any Dependent child who reaches age 26 may still be eligible under the Plan if the child is prevented from earning a living due to mental or physical handicap. To ensure continued coverage beyond age 26 for a handicapped or disabled Dependent child, you should request the necessary form from the Trust Fund Office prior to the child's 26th birth date so coverage will not be interrupted.

Child Support Orders

As required by ERISA §609(a) (2) (A), the Plan will provide coverage for a Dependent child upon receipt of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice. A QMCSO is a court order or decree that directs the Fund to provide a Participant's Dependent child with coverage under the Plan by enrolling the child or purchasing COBRA Continuation Coverage. However, a QMCSO will not qualify the child for benefits under the Plan if the child does not satisfy the Plan's eligibility requirement for the term "Dependent" nor will eligibility be provided to the child if the Participant is not eligible for benefits. The Plan will not honor a QMCSO that orders the Participant to provide a form of benefit or any option not otherwise provided to all Plan Participants or Dependents.

Special Enrollment Provision

Under the Health Insurance Portability and Accountability Act (HIPAA) and Children's Health Insurance Program Reauthorization Act (CHIPRA), if you previously declined health coverage for any of your Dependents, you have "Special Enrollment" rights to enroll them in the Plan within a specified period. These Acts require health plans to comply with your Special Enrollment rights and to inform you that if you are declining enrollment for any of your Dependents because they already have other health insurance or group health plan coverage, you may be able to enroll your Dependents in the Plan at a later date but only under certain circumstances.

SPECIAL ENROLLMENT

Refer to Article II, subsection 2.d. of the Rules and Regulations of the Plan for more details about your rights and responsibility to enroll your Dependents.

However, you must request enrollment in the Plan no later than 60 days after your Dependents' other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption or legal guardianship, you may be able to enroll your Dependents provided you request enrollment within 60 days after the date of marriage, birth, adoption, or placement for adoption or legal guardianship.

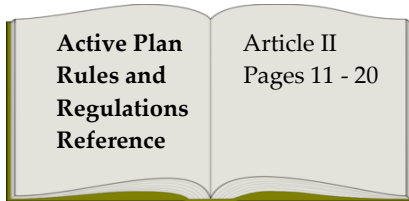
As a Participant, you also have a right **under the Plan** to:

1. Decline coverage for your current and new Dependents for any reason other than the specified reasons under HIPAA or CHIPRA.
2. Delete any Dependent from the Plan at any time.
3. Add a newly acquired Dependent in the Plan at any time or beyond the 60 days requirement under HIPAA or CHIPRA.
4. Re-enroll a Dependent that you previously deleted from the Plan at any time or beyond the 60 days requirement under HIPAA or CHIPRA.

CAUTION

Before you decline coverage for any of your Dependents or delete a Dependent already enrolled in the Plan, you should contact the Trust Fund Office first to obtain more information about your Special Enrollment rights and your Plan's enrollment procedure in general.

Eligibility for Benefits



Terms to remember that are used in this section:

“Individual Employer” means an employer required by a collective bargaining agreement to make contributions to the Fund.

“Hour Bank” means an account established for an Employee where work hours, any disability hours and the deduction of hours for coverage are recorded and tracked for purpose of establishing eligibility for benefits.

In the next several pages, you will see charts or examples that illustrate how different types of hours are recorded in your Hour Bank and how the different work hours affects your eligibility. Below is an explanation of additional terms that appear in the charts:


Work Month	The calendar month that work hours are actually performed.
Beginning Balance	The hours in your Hour Bank before work hours, if any, for a given Work Month are added to your Hour Bank. The Beginning Balance is the same as the Ending Balance for the prior calendar Work Month . The Beginning Balance cannot exceed the maximum 990 hours.
Worked Hours	The total number of work hours for a Work Month reported by Individual Employers on your behalf.
Disability Hours	If any, the number of disability hours credited to your Hour Bank due to disability. The Disability Hours will not exceed 110 hours.
Total Hours	The total of Worked Hours and Disability Hours , if any.
Eligibility Month	The calendar month in which you are eligible for benefits. You are eligible for benefits if the number of hours shown in Total Hours is at least 440.
Deduction	If the number of hours shown in Total Hours is 440 or more, 110 hours are deducted for the following calendar Work Month . No deduction is made if the Total Hours is less than 440.
Ending Balance	The balance between Total Hours and Deduction hours. The Ending Balance is carried forward to the next Work Month Beginning Balance . The Ending Balance cannot exceed the maximum 990 hours.

Employee Eligibility

Initial Eligibility

For each month that you perform work for an Individual Employer that is required to make contributions to the Fund on your behalf, your reported work hours are recorded in your Hour Bank. When the total work hours in your Hour Bank reaches at least **440**, your eligibility for benefits begins on the first day of the **second calendar month** after the month you accumulated a minimum of **440** hours.

ACCESS ELIGIBILITY RECORD ONLINE

Go to the Trust Funds'  website at www.norcalaborers.org and create an account on the Member Portal to access your eligibility record anytime.

CONTRIBUTIONS

Work hours will be credited only to your Hour Bank if your employer paid the required contributions to the Health and Welfare Trust Fund.

There is no eligibility between the month that you accumulated **440** hours and the month you became eligible. This is called the “lag month”. The purpose of the lag month is to give the Individual Employers sufficient time to report worked hours to the Trust Fund Office after the last payroll period of the month in which the hours were worked.

Chart 1 below shows how the Hour Bank works if you are a new Employee who worked between November 1st and January 31st.

Chart 1 (When Your Eligibility Begins)

Work Month	November	December	January	February	March	April	May	June
Beginning Balance	0	160	300	340	340	340	340	340
Worked Hours	160	140	150	0	0	0	0	0
Disability Hours	0	0	0	0	0	0	0	0
Total Hours	160	300	450	340	340	340	340	340
Eligibility Month	January No	February No	March Yes	April	May	June	July	August
Deduction	0	0	-110	0	0	0	0	0
Ending Balance	160	300	340	340	0	0	0	0

November Work Month:

In your first Work Month, you worked 160 hours. Since the Total Hours as of November 30th are less than 440 hours, you are not eligible for the month of January. The Ending Balance of 160 hours is carried forward to the next Work Month, December.

December Work Month:

In your second Work Month, you worked 140 hours. Since the Total Hours as of December 31st are less than 440 hours, you are not eligible for the month of February. The Ending Balance of 300 hours is carried forward to the next Work Month, January.

January Work Month:

In your third Work Month, you worked 150 hours. Because the Total Hours as of January 31st are 450 hours and exceeds the required minimum of 440 hours, you are eligible for benefits for the entire month of March. Since the Total Hours are more than the required minimum of 440 hours, 110 hours will be deducted from 450 hours currently in your Hour Bank. The Ending Balance of 340 hours will be carried forward to the next Work Month, which in Chart 1 is February.

Continuing Eligibility - How to Maintain Eligibility

Once you have accumulated at least 440 hours in your Hour Bank and have met the initial eligibility requirement shown in Chart 1, you must continue working and have at least 440 Total Hours in your Hour Bank to be eligible during the following months. After accumulating the initial 440 hours, you only need to work 110 hours each month to maintain your eligibility in the following months. However, for any month you work more than 110 hours, those excess hours will be added to your Hour Bank up to the maximum 990 hours. These extra work hours are valuable and important if you are unable to work in the future. Accumulating 990 hours in your Hour Bank will provide 8 months of future eligibility from the last month you worked.

Chart 2 below shows how the Hour Bank works if you work less than 40 hours per week after you have met the initial eligibility requirement shown in Chart 1.

Chart 2 (Maintaining Eligibility with Minimal Work Hours)

Work Month	November	December	January	February	March	April	May	June
Beginning Balance	0	160	300	340	345	335	345	345
Worked Hours	160	140	150	115	100	120	0	0
Disability Hours	0	0	0	0	0	0	0	0
Total Hours	160	300	450	455	445	455	345	345
Eligibility Month	January No	February No	March Yes	April Yes	May Yes	June Yes	July No	August No
Deduction	0	0	-110	-110	-110	-110	0	0
Ending Balance	160	300	340	345	335	345	0	0

February through April Work Months:

For each Work Month, you will continue to be eligible for the Eligibility Months of April, May and June because your Total Hours for each month are more than 440 hours.

Since the Total Hours as of April 30th are more than the required minimum of 440 hours, 110 hours will be deducted from 455 hours giving you a Beginning Balance of 345 hours as of Work Month May. If you are unable to work beginning the month of May, your eligibility will not extend beyond June 30th because you did not have enough extra hours to provide eligibility in the following months.

Chart 3 below shows how the Hour Bank works if you work more than 40 hours per week or more than 110 hours per month after you have met the initial eligibility requirement shown in Chart 1. Chart 3 shows how working extra hours in the Work Months February, March and April extend your eligibility to August 31st if you stopped working on April 30th.

Chart 3 (Maintaining Eligibility with Extra Hours)

Work Month	November	December	January	February	March	April	May	June
Beginning Balance	0	160	300	340	430	530	610	500
Worked Hours	160	140	150	200	210	190	0	0
Disability hours	0	0	0	0	0	0	0	0
Total Hours	160	300	450	540	640	720	610	500
Eligibility Month	January No	February No	March Yes	April Yes	May Yes	June Yes	July Yes	August Yes
Deduction	0	0	-110	-110	-110	-110	-110	-110
Ending Balance	160	300	340	430	530	610	500	390

Disability Hour Credit


Disability Hour Credit will help extend your eligibility during periods in which you are unable to work due to disability.

If you become disabled while working as a laborer for an Individual Employer and the Total Hours in your Hour Bank has at least 440 hours in the month in which you become disabled, you may be entitled to disability hours up to the following maximum of:

- 8 hours per day (no credit given for Saturdays and Sundays)
- 40 hours per week
- 110 hours per month
- 660 hours during any 12-consecutive month period

DISABILITY CERTIFICATE

Contact the Trust Fund Office or download the form from the Trust Funds'  website at www.norcalaborers.org.

In order to receive Disability Hour Credit, request a Disability Certificate form from the Trust Fund Office, your local union office, or you can print the form from the Trust Funds'  website at www.norcalaborers.org. Your doctor must complete Part I; you must complete Parts III and IV. Part II is for Disability Hour Credit for the Laborers Pension Trust Fund for Northern California.

FILING DEADLINE

You must file a Disability Certificate within one year from the date your disability began.

Disability hours will only extend your eligibility for benefits up to 6 months during any 12-consecutive month period. It will not add to your Hour Bank since the maximum allowed is 110 hours and is offset by the 110 hours deduction for each month to maintain your eligibility.

Chart 4 below shows the effect on your Hour Bank and eligibility if you are granted disability hours for Work Months February – May, assuming your disability began in the middle of February and you returned to work in June. If you are still disabled after May, you will be entitled to a maximum of 250 disability hours through January 31st of the following year. These additional months of eligibility are because as you had already been granted 410 disability hours during the 12-month period beginning in February.

Chart 4 (Disability Hours)

Work Month	November	December	January	February	March	April	May	June
Beginning Balance	550	540	460	470	520	520	520	520
Worked Hours	100	30	120	80	0	0	0	160
Disability Hours				80	110	110	110	0
Total Hours	650	570	580	630	630	630	630	680
Eligibility Month	January Yes	February Yes	March Yes	April Yes	May Yes	June Yes	July Yes	August Yes
Deduction	-110	-110	-110	-110	-110	-110	-110	-110
Ending Balance	540	460	470	520	520	520	520	570

Family Medical Leave Act

If you are on a medical leave of absence that is covered by Family Medical Leave Act (FMLA), your Individual Employer is required to make contributions to the Fund for the period you are on leave but, no longer than allowed by FMLA which at this time is 12 weeks (or in some cases, up to 26 weeks). While you are on FMLA leave, you are not entitled to Disability Hour Credit. If you are still disabled once your employer has made the maximum contributions required by FMLA, you may apply for Disability Hour Credit.

FMLA ELIGIBILITY

It is not the responsibility of the Trust Fund Office to determine your eligibility to FMLA. You should contact your employer if you have any questions about FMLA.

Reciprocity Credit

There may be occasions when you work as a laborer outside of the Northern California jurisdiction. There may also be occasions when your employer requests that you perform covered work outside of the Northern California jurisdiction. Regardless of the reason for working outside of Northern California, you should contact your local union office or the Trust Fund Office because under some circumstances, you may be entitled to have contributions for your work hours for the Health and Welfare Plan “follow you” back to your home area—this is called “reciprocity”.

If you do not contact the Trust Fund Office or your local union, you may lose valuable work hours that would allow you to be eligible for benefits. If you do not qualify for the type of “reciprocity”, where contributions “follow you” back to your home area and you have a Claim for any month in which you are not eligible for benefits under the Fund or in the jurisdiction where you are working, there may be another form of Reciprocity available **on a per Claim basis**. You should contact the Trust Fund Office if you have questions or to see if you qualify for any form of reciprocity.

Employee Termination of Eligibility

Your eligibility ends on the last day of the month following the month in which your Hour Bank balance drops below 440 hours. The Charts 1, 2 and 3 in the Initial Eligibility section also shows how the Hour Bank works for a new Employee who gained eligibility and then stopped working on April 30th.

EXCEPTIONS - Extension of Eligibility

In cases of death or retirement, your eligibility will extend for 3 additional months after your Hour Bank drops below 440 hours. This same provision applies to your eligible Dependents as well.

Chart 5 below shows how the Hour Bank works for the two exceptions described below assuming you have at least 440 hours in your Hour Bank on the effective date of your pension or your date of death. For example: on January 15th the chart shows that eligibility is provided for Eligibility Months April, May and June even though the Total Hours in your Hour Bank for those months was less than 440. Once the 3 months extension expires, the remaining balance of 350 hours in your Hour Bank is cancelled.

Chart 5 (3 Months Extension of Eligibility)

Work Month	November	December	January	February	March	April	May	June
Beginning Balance	550	540	460	350	350	350	0	0
Worked Hours	100	30	0	0	0	0	0	0
Disability Hours	0	0	0	0	0	0	0	0
Total Hours	650	570	460	350	350	350	0	0
Eligibility Month	January Yes	February Yes	March Yes	April Yes	May Yes	June Yes	July No	August No
Deduction	-110	-110	-110	0	0	-350	0	0
Ending Balance	540	460	350	350	350	0	0	0

Retirement

If you are a Participant who is receiving a pension from the Laborers Pension Trust Fund for Northern California or from the Retirement Plan for Certain Employees of Laborers Funds Administrative Office of Northern California Inc. and you have at least 440 hours in your Hour Bank on the effective date of your pension, you may use the remaining hours in your Hour Bank for 3 additional months of eligibility. After you have exhausted your hour bank, you will be given a choice of enrolling in the Laborers Retired Plan or continue in the Active Plan's COBRA continuation coverage for 18 months.

Death

If you are a Participant who dies with at least 440 hours in your Hour Bank and you have enrolled Dependents, your Dependents will be able to use the remaining hours in your Hour Bank for 3 additional months of eligibility.

Earlier Termination of Eligibility

In cases of employment for an Employer who is not signatory to a collective bargaining agreement with the Laborers or you die without a Dependent, your eligibility will terminate earlier than usual even though you may have 440 hours or more in your Hour Bank.

Military Service

Your eligibility for benefits ends when you enter military service, other than for a temporary tour of duty of 30 days or less. Special reinstatement rules apply upon your return to work from active military service for longer periods of time. For example, you must notify the Trust Fund Office within 90 days from the date you were discharged from military service if you served for at least 181 days. Once you return to work, your Hour Bank balance will be reinstated to the level it was prior to your entry into the military.

MILITARY SERVICE

Refer to Article II, Subsection 2.a.(6) of the Rules and Regulations of the Plan for more information about Military Service.

Military Service

This section will explain how the Plan works with your rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA), a federal law.

USERRA Continuation Coverage

On the date you enter active duty military service **for more than 30 days**, your eligibility and that of your Dependents will end under the Plan. The Fund, however, must provide you with Plan continuation options and reinstatement rights in accordance with USERRA.

In order for the Fund to provide you with information about USERRA Continuation Coverage, you must first notify the Board as soon as possible but no later than 60 days, that you have entered active military service. When the Trust Fund Office, on behalf of the Board, receives your notice, you will be

provided with information about your rights to continue your health plan coverage through self-payments under USERRA Continuation Coverage for up to 24 months **or** COBRA Continuation Coverage for up to 18 months.

Cost for USERRA Continuation Coverage

The cost for USERRA Continuation Coverage is determined in the same way as COBRA Continuation Coverage. Refer to Cost of COBRA Continuation Coverage section on page 35.

TRICARE

When you are on active duty or if you are retired military, you may also have access to coverage through TRICARE, the Department of Defense health care program for uniformed service members and their families. If this option is available to you, you should contact TRICARE for information about enrollment and how TRICARE works with any other Group Plan or Medicare.

After Discharge from Military Service

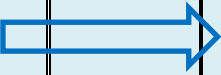
When you are discharged from active duty military service (not less than honorably) and you make yourself available for Covered Employment within the jurisdiction of the Fund, your Hour Bank and eligibility will be reinstated to the same level as on the date you entered military service. To have your Hour Bank reinstated, **you must have filed notice on a form that has been approved by the Board and within the following time frames:**

- **For military service of less than 31 days:** You must file notice with the Board at the beginning of the next regularly scheduled work period on the day following discharge (plus travel time and an additional 8 hours).
- **For military service of 31 days but less than 181 days:** You must file the notice with the Board within 14 days from the date of discharge; **or**
- **For military service of 181 days or more:** You must file the notice with the Board within 90 days from the date of discharge;

If you are hospitalized or convalescing from an injury caused by active duty, these time frames will be extended by two years.

Chart 6 below shows the effect of military service on your Hour Bank. Your Ending Balance as of the time you left for active duty is reinstated once you return to work as a laborer within the required timeframes.

Chart 6 (Military Service)

Work Month	November 2015	December 2015	January 2016		January 2017	February 2017
Beginning Balance	550	640	710	 If you were in Military Service from January 2016 and returned to work one year later	710	720
Worked Hours	200	180	MILITARY DUTY		120	150
Disability Hours	0	0	0		0	0
Total Hours	750	820	710		830	870
Eligibility Month	January Yes	February Yes	March No		March Yes	April Yes
Deduction	-110	-110	-710		-110	-110
Ending Balance	640	710	0		720	760

Cancellation of Hour Bank

After termination of eligibility, the hours in your Hour Bank will remain until you have worked sufficient hours to regain eligibility. You must work to bring the Total Hours in your Hour Bank back to the required minimum of 440 hours **within 13 months** from the last month that you were eligible. If you do not regain eligibility within 13 months from the last month of eligibility, any hours remaining in your Hour Bank will be cancelled.

If you are not able to work due to disability and you lose the hours remaining in your Hour Bank after 13 months, you may petition the Board of Trustees, in writing, to reinstate the hours you lost. Your disability must be due to an illness or injury that occurred while you were a laborer eligible under the terms of the Plan and you must submit satisfactory proof of your disability.

Chart 7 below shows the effect on your Hour Bank if you fail to regain eligibility within the allowed 13-month period. Your Ending Balance will remain at 350 hours for next 12 months and at the 13th month those hours will be cancelled.

Chart 7 (Hour Bank is Cancelled)

Work Month	November 2015	December 2015	January 2016	Forward to February 2017 Work Month (13 months from January 2016)	January 2017	February 2017
Beginning Balance	550	540	460		350	0
Worked Hours	100	30	0		0	0
Disability Hours	0	0	0		0	0
Total Hours	650	570	460		350	0
Eligibility Month	January Yes	February Yes	March Yes		March No	April No
Deduction	-110	-110	-110		0	0
Ending Balance	540	460	350		350	0

Dependents Eligibility

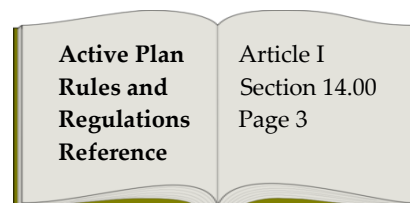
Eligibility

Your Dependents will be eligible for benefits on the later of:

- The date you become eligible, or
- The date your Dependent has satisfied the requirements of the Plan for Dependent eligibility. Refer to page 16 for the type of documents you must provide to satisfy the Plan's Dependent eligibility requirements.

You may enroll the following Dependents in the Plan:

- Your lawful spouse, or
- Your Domestic Partner, and
- Your or your Domestic Partner's children under the age of 26. Dependent children are covered until the end of the month in which they turn age 26 and includes:
 - Natural born children,
 - Stepchildren,



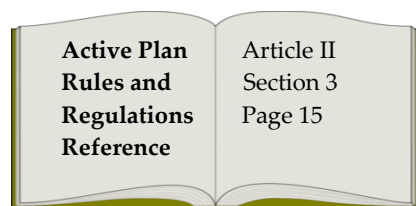
- Adopted or foster children placed in your home or children acquired through legal guardianship. These children are covered on the date you become legally obligated to provide full or partial support for the child.
- Disabled or handicapped children, upon reaching age 26, who are prevented from earning a living may also be covered under the Plan so long as the child was eligible under the Plan immediately prior to becoming age 26. In order for the coverage to be tax exempt, the Dependent child must be claimed on your income tax return for each Plan Year for which coverage is provided.
- A Dependent child or children if you are required by a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice as described in the Employee Retirement Income Security Act (ERISA) of 1974 section 609(a)(2)(A) to provide health care coverage.

Termination

Your Dependents eligibility for benefits will terminate on the earlier of:

- The date your eligibility ends, or
- The date your Dependent no longer qualifies as a Dependent under the Plan.

COBRA Continuation Coverage



The Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law enacted in 1986, requires that when eligibility under the Plan ends, certain Qualifying Events permit a Qualified Beneficiary to continue health plan coverage for a period of time and depending on the reason eligibility was lost. The type of Qualifying Event determines the duration of COBRA Continuation Coverage available.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. The Marketplace helps people without health coverage find and enroll in a health plan. For California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov. Also, if you purchase health insurance in the Marketplace, you may be eligible for a tax credit that lowers your monthly premiums for that insurance coverage. Being **eligible** for COBRA does not limit your chances for purchasing coverage or for a tax credit. You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Qualified Beneficiary

A Qualified Beneficiary is any individual who was eligible for hospital-medical, dental and vision benefits on the day before a Qualifying Event occurred.

DOMESTIC PARTNER

The Plan does not provide or offer COBRA continuation coverage to the dependent Domestic Partner or his children as Group Plans are not required by any federal law to provide such coverage.

Qualifying Events

If any of the Qualifying Events listed below occurs, a Qualified Beneficiary has the right to continue the health plan benefits that were in effect on the day before the Qualifying Event occurred. To continue coverage, the Qualified Beneficiary must apply for COBRA Continuation Coverage and make the required monthly payments to the Fund within the specified time frames. Those Qualifying Events are:

1. Your termination of employment or retirement.
2. Work hours reported on your behalf by an Individual Employer are less than the required monthly minimum for continued eligibility and you do not have enough hours accumulated in your Hour Bank to cover the monthly minimum for continued eligibility.
3. Your death.
4. Your divorce or legal separation from your Dependent spouse.
5. Your child loses status as a Dependent under the Plan.

Duration of COBRA Continuation Coverage

If you or your Dependents qualify for COBRA Continuation Coverage, you or your Dependents can elect coverage for up to 18, 29, or 36 months, depending on the Qualifying Event:

- **18 Months:** A Qualified Beneficiary, can continue coverage for up to 18 months from the date of the Qualifying Event if the Qualifying Event was because an Individual Employer ceased to make contributions to the Fund on your behalf causing a loss of eligibility under the Plan.
- **29 Months:** Any Qualified Beneficiary can extend the 18-month period by 11 months, for a total of 29 months, if the Qualified Beneficiary becomes disabled, as determined by the Social Security Administration, before or during the first 60 days of COBRA Continuation Coverage.
- **36 Months:** Qualifying Events 2, 3 and 4 entitle your Dependents to up to 36 months of COBRA Continuation Coverage from the date of the Qualifying Event. (In the case of a child's losing Dependent status, only the affected child is eligible for 36 months of coverage.)

Extension in Cases of Disability

If a Qualified Beneficiary becomes totally disabled before or during the first 60 days of COBRA Continuation Coverage, COBRA may be extended for an additional 11 months, for a total of 29 months. To qualify for the extension, the Qualified Beneficiary must be considered totally disabled by the Social Security Administration. All family members of the disabled individual are entitled to the additional 11-month extension of COBRA.

NOTE: The cost for the additional 11 months of COBRA Continuation Coverage will be approximately 50% higher than the cost charged during the first 18-months of COBRA Continuation Coverage.

Extension in Cases of a Second Qualifying Event

If, during the 18-month period of COBRA Continuation Coverage, you die, you divorce or a Dependent child loses his Dependent status under the Plan, the maximum period of COBRA Continuation Coverage for your spouse and Dependent children can be extended to 36 months **from the date of the first Qualifying Event**.

Effect of Medicare Entitlement

Before a Termination of Employment or Reduction in Hours

If you are a Participant and the reporting of insufficient work hours occurs less than 18 months after the date you became entitled to Medicare (Part A, Part B, or both), the maximum period of COBRA Continuation Coverage for your Dependents will be 36 months from the date of your Medicare entitlement.

For example:

- Your Qualifying Event (QE) is January 1, 2016 (based upon a reduction in hours).
- You were entitled to Medicare on June 1, 2015 (6 months before the QE).
- You are entitled to COBRA Continuation Coverage for 18 months from January 1, 2016.
- Your Dependents are entitled to 36 months of COBRA Continuation Coverage from June 1, 2015 (your Medicare entitlement date) or 30 months from the QE (36 less 6 months).

After a Termination of Employment or Reduction in Hours

Medicare entitlement is not a Qualifying Event under this Plan. Medicare entitlement after a termination of employment or the reporting of insufficient hours will not extend a Qualified Beneficiary's COBRA coverage beyond 18 months.

For example:

- Your Qualifying Event is January 1, 2016 (based upon a reduction in hours).
- You are entitled to Medicare on June 1, 2016 (6 months after your QE).
- Your COBRA Continuation Coverage ends on June 1, 2016 (the date of your Medicare entitlement).
- Your Dependents can continue COBRA for the full 18 months from January 1, 2016.

Benefits Available Under COBRA Continuation Coverage

A Qualified Beneficiary may elect the entire package of benefits called "Core Benefits" which include the same hospital-medical, prescription Drug, dental and vision coverage provided by the Plan to the Qualified Beneficiary the day before the Qualifying Event. However, the Qualified Beneficiary has the right to reject "Non-Core Benefits" which include dental and vision care. Dental and vision care (Non-Core Benefits) cannot be purchased separately or without hospital-medical benefits.

Overview of COBRA Continuation Coverage Options

Non-Core Benefits	Core Benefits (Entire package)
Benefits include Dental and Vision Care only	Benefits include Hospital-Medical, Prescription Drug, Dental and Vision Care
Death and Accidental Death and Dismemberment benefits are NOT available under COBRA Continuation Coverage	

Duty to Notify the Trust Fund Office

The Trust Fund Office will know when you lose eligibility under the Plan as a result of a reduction in work hours. The Trust Fund Office will also know when an enrolled Dependent child has reached age 26 and is no longer an eligible Dependent under the Plan. You do not need to provide notice to the Trust Fund Office of these Qualifying Events.

However, it is the Qualified Beneficiary's responsibility to provide timely written notice to the Trust Fund Office of any of the following Qualifying Events:

1. Your divorce or legal separation.
2. Your death.
3. Your handicapped child over the age of 26 loses Dependent status under the Plan.
4. The occurrence of a second Qualifying Event while your Dependents are in an 18-month COBRA Continuation period.
5. You or your Dependent have a Qualifying Event that entitles you to COBRA Continuation Coverage with a maximum duration of 18 months and the Social Security Administration determines that one of you is disabled; or
6. The Social Security Administration determines that the individual is no longer disabled.

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs. Covered employees may elect COBRA on behalf of their spouses and covered parents or legal guardians may elect COBRA for a minor child.

Notice from one Qualified Beneficiary will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event. For example, if your spouse notifies the Trust Fund Office that your handicapped child no longer meets the definition of "Dependent" under the Plan, the single notice would satisfy the notice requirements.

Timely Notice to the Trust Fund Office

If the notice that is being provided is of a divorce or legal separation, a handicapped Dependent child over the age of 26 losing eligibility, or a second Qualifying Event, you or a Qualified Beneficiary must provide written notice to the Trust Fund Office, no later than 60 days after the date of the Qualifying Event.

If notice is being provided in order to qualify for the additional 11 months of COBRA due to disability, the Qualified Beneficiary must report the Social Security disability determination to the Trust Fund Office before the end of the original 18 month COBRA period **and** provide a copy of the Social Security Administration disability determination letter within 60 days from the date on the determination letter.

If notice is being provided about a Social Security Administration determination that the Qualified Beneficiary is no longer disabled, written notice must be provided to the Trust Fund Office no later than

ALWAYS NOTIFY
If the Trust Fund Office is not notified timely, all Qualified Beneficiaries will lose their COBRA enrollment rights. To ensure prompt handling of your COBRA rights, you should notify the Trust Fund Office of any COBRA Qualifying Event.

30 days from the date of the Social Security Administration determination that the person is no longer disabled.

How to Notify the Trust Fund Office

When a Qualified Beneficiary provides timely notice, **in writing**, to the Trust Fund Office of any of the Qualifying Events, the notice must include:

- The name of the Qualified Beneficiary;
- The Participant's name and Health Plan Identification number or Social Security number;
- The event for which notice is being provided and the date of the Qualifying Event (for example, the date a handicapped Dependent child is losing Dependent status as a handicapped child, the Participant's death, or the date of divorce or legal separation, etc.); **and**
- A copy of the final judgment of dissolution of marriage if the Qualifying Event is a divorce or a copy of the court order confirming a legal separation from your Dependent spouse.

Where to Send Your Notice of a Qualifying Event

Notice of a Qualifying Event should be sent to the Trust Fund Office at the following address:



**Laborers Health and Welfare Trust Fund
for Northern California
Attention: COBRA Department
220 Campus Lane
Fairfield, CA 94534-1498**

Electing COBRA Continuation Coverage

After receiving notice of a Qualifying Event, the Trust Fund Office will send the Qualified Beneficiary a notice of his right to choose COBRA Continuation Coverage, along with an **Election Form**. If you or your Dependents do not qualify for COBRA Continuation Coverage, a Notice of "Unavailability of COBRA Continuation Coverage" will be sent. These notices will be sent within 14 days from the date the Trust Fund Office receives notice of a Qualifying Event. It is very important that you keep your address and that of your Dependent(s), if they live at an address other than yours, current so the Trust Fund Office can communicate with you and your Dependents.

The Qualified Beneficiary must sign, date and return the **Election Form** to the Trust Fund Office no later than 60 days after the date eligibility is lost or the date the Qualified Beneficiary receives the COBRA notice from the Trust Fund Office, whichever is later or the Qualified Beneficiary will not be eligible for COBRA Continuation Coverage. If the Qualified Beneficiary does not file the COBRA **Election Form** within this 60-day period, the Qualified Beneficiary will lose rights to COBRA Continuation Coverage.

DO NOT FORFEIT

Return the Election Form even if you think you will regain eligibility by working again so you do not lose your COBRA rights.

If you do not choose COBRA Continuation Coverage for yourself, your health insurance coverage will end. However, your spouse and eligible Dependents may elect COBRA Continuation Coverage regardless of your decision.

Cost of COBRA Continuation Coverage (Monthly Premium)

COBRA Continuation Coverage is only available at your own expense.

The monthly premium rates for COBRA Continuation Coverage will be outlined in the Notice of Entitlement to COBRA Continuation Coverage. If a Qualified Beneficiary elects COBRA Continuation Coverage, the full cost of the benefit plan, plus a 2% administrative fee will be charged (in the case of the 11 month extension due to a disability, the charge is the full cost of the benefit plan plus 50%). The premium rates are subject to future increases during the COBRA Continuation Coverage period. If the premium rates change, the Trust Fund Office will revise the charge a Qualified Beneficiary is required to pay and send a notice 30 days prior to the change. In addition, if the benefits change under the Plan, the benefits under COBRA Continuation Coverage will change as well.

PREMIUM RATES

The monthly premium rates for COBRA usually change every March.

Paying for COBRA Continuation Coverage

Qualified Beneficiaries are given an initial grace period of **45 days** from the date COBRA Continuation Coverage was elected to pay the first COBRA premium.

If the first premium payment is not made when due, COBRA Continuation Coverage will not take effect. After the first payment, all future payments are due on the first day of the month for which coverage is provided. There is a grace period of **30 days** to pay the monthly premium. If the Qualified Beneficiary does not pay the premium by the end of the grace period, COBRA Continuation Coverage will terminate. **IMPORTANT:** Making the payment during the grace period may affect eligibility during the grace period. The payment must be made before eligibility can be confirmed should any health care provider ask the Trust Fund Office about a Qualified Beneficiary's eligibility status.

NO SKIPPING OF PREMIUM PAYMENT

Payments for COBRA coverage are applied on a month to month basis. The Plan does not allow Qualified Beneficiaries to pay for COBRA coverage only when benefits are used.

The first COBRA payment must cover the period from the date coverage terminated under the Plan up to the current month's coverage. For example, if coverage terminated on September 30, 2015 and the Qualified Beneficiary returns the **Election Form** so that it is received by the Trust Fund Office no later than November 29, 2015 (within 60 days from the loss of eligibility), the first payment is due no later than January 13, 2016 (within 45 days of the November 29th election). This payment must include COBRA premiums for October, November and December 2015. In addition, the payment for January 2016 coverage must be received no later than January 30, 2016 which is the end of the grace period.

Adding New Dependents

If, while enrolled for COBRA Continuation Coverage, a Qualified Beneficiary acquires a new Dependent, he may enroll the new Dependent for coverage for the balance of the period of COBRA Continuation Coverage. However, the enrollment of a new Dependent must occur **within 60 days** from the date that the Qualified Beneficiary acquires the new Dependent. Adding a new Dependent may cause an increase in the amount that must be paid for COBRA Continuation Coverage.

Special Enrollment for the Balance of Your COBRA Continuation Period

If you have an eligible Dependent who did not enroll for COBRA Continuation Coverage when it was first offered because they had other health plan coverage and that coverage is subsequently lost, you may enroll that Dependent for the remainder of your COBRA Continuation period. For this to occur:

- Your Dependent must have been eligible for COBRA Continuation Coverage on the date of the Qualifying Event but declined when enrollment was offered because he had coverage under another group health plan or had other health insurance coverage;
- Your Dependent must exhaust his other coverage, lose eligibility for it, or lose employer contributions to it, **and**
- You must enroll that Dependent by sending an Enrollment Form to the Trust Fund Office **within 60 days** after the termination of other coverage or contributions.

Changing Plans

A Qualified Beneficiary should not assume his hospital-medical, dental or vision plan has been changed until a written confirmation has been received from the Trust Fund Office. Refer to Health Plans Available and Options section on page 6 for more information about changing plans.

Hospital-Medical Plans

Qualified Beneficiaries have the right to change hospital-medical plans up to twice in a calendar year just like Participants. To change a plan while enrolled in COBRA, the Qualified Beneficiary should contact the Trust Fund Office for an Active Plans' Application Form. The application is also available on the Trust Funds' website. Complete and submit the application to the Trust Fund Office. Once the application has been processed by the Trust Fund Office, the Qualified Beneficiary will be notified in writing, confirming the plan and the effective date of the change.

Dental and Vision Plans

If a Qualified Beneficiary selected the Core Benefits (entire package) when first enrolled for COBRA, he can change his dental plan or his vision plan (for Qualified Beneficiaries enrolled in Kaiser Permanente Plan) only during the annual Open Enrollment (OE) period for dental and vision plans from December 1st through February 15th for a March 1st effective date just like Participants.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate at the end of the maximum continuation period allowed (18, 29, or 36 months). COBRA Continuation Coverage will terminate before the end of the 18, 29, or 36 month period if one of the following events occurs:

1. The Qualified Beneficiary fails to pay the required premium payments in full and on time;
2. The Qualified Beneficiary becomes covered under another group health plan after the date he elected COBRA Continuation Coverage;
3. The Qualified Beneficiary becomes entitled to Medicare Part A or Part B after the date of his COBRA election;
4. Your employer no longer provides group health coverage to any of its Employees; **or**
5. The Qualified Beneficiary has received a final determination from the Social Security Administration that the Qualified Beneficiary is no longer disabled.

COBRA Continuation Coverage will terminate on the first day of the month following any of the events listed above. The Trust Fund Office will send you a written notice as soon as practicable following a decision that continuation coverage has or will terminate.

IMPORTANT: Keep your enrollment information and contact information that is on file at the Trust Fund Office current. If you have changed marital status, or you or your spouse or other Dependents have changed addresses, contact the Trust Fund Office immediately. Notify the Trust Fund Office of any Qualifying Event, even if you think you are not required to give notice to the Trust Fund Office.

Should federal or state law change the provisions of COBRA in existence after this SPD is printed, Participants or Qualified Beneficiaries will be advised of these changes as required by law.

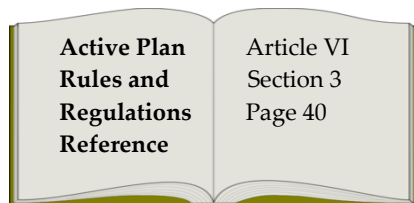
Quick Reference Chart

Qualifying Event	Qualified Beneficiary	Maximum Period
Reduction in your minimum required work hours	You, your Dependent spouse and children	18 months*
Termination of your employment	You, your Dependent spouse and children	18 months*
Your death	Your Dependent spouse and children	36 months
Your divorce	Your Dependent spouse and children	36 months
Your child's loss of Dependent status	Your child	36 months
* Extended to 29 months - if you or one of your Dependents is disabled prior to end of the initial 18-month period. A higher premium is applicable for the additional 11 months; Extended to 36 months for your Dependents – if a Second Qualifying Event occurs within the first 18-month period.		

KAISER MEMBERS

Call Kaiser Member Services for information about your rights to elect post-COBRA extended coverage California law or enroll in Kaiser conversion plan.

Other Insurance Coverage – Coordination of Benefits



This section summarizes the provisions of the Plan to help you understand how coordination of benefits (COB) is applied to your and your Dependents' Claims. This is not a complete description of all of the COB rules and procedures and does not replace the language contained in the Plan Rules and Regulations. If this outline

or overview does not answer your questions, call the Trust Fund Office for assistance or consult the Plan Rules and Regulations.

It is common for family members to be covered by more than one Group Plan. This happens for example when both you and your spouse are working and both employers provide health care coverage to their employees and family members. When both spouses have Group Plan coverage through their employer, they have "dual coverage". If you and any of your Dependents have dual coverage, the Fund must follow a procedure called "coordination of benefits" (COB). COB rules determine which Group Plan must pay first and how much to pay when you and your eligible Dependents file a Claim. Proper application of these rules will assure that the combined payments of the two Group Plans does not exceed 100% of the amount of benefits that you are entitled to receive.

This Plan does not coordinate benefits with an individual plan. This means that when a Participant is covered by this Plan and also covered by an individual (non-group) plan or policy, **including a policy through the Health Insurance Marketplace**, this Plan will not pay benefits toward the unpaid amount related to claims resulting from an individual plan or policy.

COB covers a wide variety of circumstances. Below is an outline of some of the more common situations.

Coordination with a Group Plan

Order of Benefit Determination

"Order of benefit determination" decides which Group Plan pays first (the primary insurance), and which Group Plan pays second (the secondary insurance) and if any, which Group Plan pays third and so forth.

You will be asked to supply the Trust Fund Office with the name of any other Group Plans that covers you and your eligible Dependents. The Trust Fund Office needs this information in order to determine the order in which the Group Plans pay benefits. If your Dependents have other Group Plan coverage and you fail to inform the Trust Fund Office, you will be required to reimburse the Fund for any claims the Plan paid as primary payer rather than secondary payer.

OTHER INSURANCE INQUIRY FORM

If any of your Dependents has other Group Plan health care coverage or obtains coverage in the future, you must call the Trust Fund Office to determine which Plan is the primary payer.

Primary Payer

If your spouse has other Group Plan coverage, this Plan, in general, will be the primary payer when the Claim submitted is for:

- You.
- Your spouse if she is a **RETIRED EMPLOYEE** under her former employer's Group Plan and she also **HAS MEDICARE** coverage.
- Your Dependent child if your month and day of birth are **BEFORE** your spouse's.
- Your Dependent child if you are divorced and **YOU** have custody of that child.

When the Plan is the primary payer, benefits are limited to the Plan's Allowed Charges or Maximum Plan Allowance and subject to all of the Plan's terms and provisions regardless of the secondary payer's payment.

Any Group Plan that does not have a COB provision will always pay first as "primary" before any other Group Plan.

Secondary Payer

This Plan will be the secondary payer when the Claim submitted is for:

- Your spouse.
- Your Dependent child if your month and day of birth are **AFTER** your spouse's.
- Your Dependent child if you are divorced and your **EX-SPOUSE** has custody of that child.

When the Plan is the secondary payer, benefits are still limited to the Plan's Allowed Charges or Maximum Plan Allowance and subject to all of the Plan's terms and provisions. However, the Plan will deduct the primary payer's payment and pay the lesser of:

- The normal Plan benefits.
- The Eligible Individual's out-of-pocket share. If the primary payer is a prepaid plan or a HMO, this Plan will only pay the Eligible Individual's copayment or share of the cost.
- The unpaid balance, but will not exceed the maximum amount allowed the provider of service is entitled to receive. If the provider has entered into a Preferred Provider Agreement (PPO) with this Plan or the primary payer, this Plan will consider the lesser of the provider's contractual rate maximum amount allowed by the Plan.

Coordination with Federal Supplemental Medicare

Medicare is usually the secondary payer to active employees who have Medicare coverage and are also covered under their employer's Group Plan. (Different COB rules apply to individuals who have Medicare because of end stage renal disease (ESRD) or had a kidney transplant). This Plan will pay before Medicare, while you are eligible as an Active Employee, when the Claim submitted is for:

- You.
- Your spouse if she is a Dependent under your Plan and she has no other Group Plan coverage as an active employee.
- Your disabled child with Medicare coverage and he has no other Group Plan coverage as a dependent of an active employee.

Coordination with Medicaid or Medi-CAL

In any case where this Plan is required to reimburse the State for claims incurred by you or any of your Dependents, the Plan will pay the State, subject to all Plan provisions, the lesser of the normal Plan benefits or the amount actually paid by the State.

STATE LAW

The Plan is required to share certain information with the State including the names and SSNs of all the members and Dependents who are eligible under the Plan.

Affordable Care Act

Introduction

The federal health care law known as the “Affordable Care Act” (ACA) was signed into law on March 23, 2010. The law requires that all health plans provide certain consumer protections such as:

- Coverage for children to the age of 26 regardless of marital or dependency status; **and**
- No annual or lifetime dollar limits on Essential Health Benefits (EHB).

KAISER MEMBERS


Refer to your Plan’s Evidence of Coverage (EOC) pamphlet for detailed information about your Plan’s grandfathered status.

ACA also requires that certain health plans provide additional consumer protections if they are “non-grandfathered” plans. However, the Direct Payment Plan is considered as a “grandfathered” health plan and is allowed to maintain certain basic benefits that were in effect before the law was passed. Being a grandfathered health plan means that the benefits provided under the Direct Payment Plan are not required to include certain consumer protections of the ACA that apply to other plans. For example, the Plan is not required to provide preventive health services without cost sharing.

Summary of Benefits and Coverage (SBC)

ACA also requires all health plans provide a completed SBC form to individuals covered under their plans. The Trust Fund Office provides this form:

- Immediately after your initial eligibility as part of the enrollment process;
- 30 days prior to the beginning of the ERISA Plan Year which is June 1st; **and**
- 60 days prior to the effective date of a change considered a major or significant change in benefits and affects the information on the SBC.

You can always read or print a copy of the most recent SBC from the Trust Funds’  website at www.norcalaborers.org.

The purpose of the SBC form is to help compare health plans when shopping for health plan coverage in the Health Insurance Marketplace which opened in 2014. The Health Insurance Marketplace is set up to provide one central location to find health plans and help consumers compare available plan options. The comparison includes prices, benefits, service and quality of care information. The SBC is a standardized form and cannot be altered to fit the Fund’s health plans—this is to make it easier to compare the many plans that are offered in the Health Insurance Marketplace.

Any change in benefits that affects the information on the SBC will generate a new SBC with the effective date of the benefit change through the end of the **ERISA Plan Year, i.e. June 1st**.

Helpful Tips: When you see “**coverage period**” on the SBC, it is referring to the ERISA Plan Year which is the Fund’s “fiscal year” or accounting year (June 1 – May 31). The Fund’s “benefit” Plan Year is March 1 – February 28 and is the period in which you and your Dependents accumulate your annual Deductible, your annual Out-of-Pocket Maximum (your annual cost-sharing limits) and the period in which any annual benefit limitations apply.

The Health Insurance Marketplace

While you remain eligible under one of the plans offered by the Fund, you will have no need to shop for individual health plan coverage in the Health Insurance Marketplace.

Generally, you cannot enroll in a Health Insurance Marketplace plan outside of the annual Open Enrollment (OE). There is, however, a “Special Enrollment Period” where certain “**Qualifying Events**”, as defined by the ACA law, permit you and your Dependents to enroll in a Health Insurance Marketplace plan outside of the usual OE period. Special rules may also apply if you have enrolled in COBRA Continuation Coverage. For more information contact www.coveredca.com if you live in California or www.healthcare.gov if you live elsewhere in the United States.

MINIMUM STANDARD

The Direct Payment Plan meets the Minimum Essential Coverage (MEC) and Minimum Value Standard (MV) required under the ACA law.


Nondiscrimination in Health Care

To the extent that an item or service is a covered benefit under this Plan, the Fund will not discriminate with respect to your choice of a health care provider so long as that health care provider is licensed by the state in which he practices and is operating within the scope of his license.

Preferred Provider Network Program

Under the Direct Payment Plan, you and your eligible Dependents have the freedom to choose your own health care providers, such as Hospitals, Physicians, laboratories, radiologist, and others various types of providers who are qualified by their license to provide services covered by the Plan.

PROVIDER SEARCH

Anthem Blue Cross
 www.anthem.com/ca

When you and your Dependents choose to use Participating Hospitals, Providers or Value-Based Site Providers that are part of the Fund's Preferred Provider Plan network, your share of the cost for covered health care services is lower.

The Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) is a managed care organization of Hospitals and other licensed health care providers who have an agreement to accept lower fees for their services. The lower fees are referred to as "negotiated rates". The agreements are between Anthem Blue Cross (ABC) and the Participating Hospitals and Participating Providers.

Among the services for which the Fund contracts with ABC is access to Preferred Provider Plan networks. This allows you and your Dependents to receive lower negotiated rates on Covered Expenses as well as a lower coinsurance amount—both of which reduce your share of the cost for Covered Expenses.

The Preferred Provider Plan (PPO Plan)

ABC has several Preferred Provider Plan networks. The Preferred Provider Plans used by the Fund are **1) the PPO network** if you live in California; **and 2) the BlueCard PPO national network** if you live or are traveling elsewhere in the United States.

The BlueCard PPO

PROVIDER SEARCH

BlueCard
 www.bluecares.com

This is the national PPO network to be used outside of California but still within the United States. Using **BlueCard PPO** Participating Hospitals and Providers assures you of receiving lower negotiated rates for Covered Expenses as well as lowering your coinsurance amount—both reduce your share of the cost for Covered Expenses.

No coverage is provided under the Direct Payment Plan for services received outside of the United States, its Territories or Possessions with the exception of Emergency Services as defined by the Plan.

Before you receive medical services, you should confirm whether or not you are using a Participating Hospital and/or Participating Provider from the Fund's Preferred Provider Plan network, the **PPO** or **BlueCard PPO** national network.

How to Locate a Participating Hospital or Participating Provider

The easiest way to find Participating Hospitals or Providers is to use the ABC website (www.anthem.com/ca). Choose the “USEFUL TOOLS” section and then “FIND A DOCTOR”.

CAUTION

If you use the ABC website, you should do so only for limited services because not all features on the website apply to you. For instance, the Drug and Dental benefits are not through ABC so you will not use those features on the ABC website. When using the ABC website, do so with caution because some of the information you may need will come from companies other than ABC.

When you or your Dependents register with the ABC website, you will need a user name and password. This will give you access to the names and locations of Participating Hospitals and Providers that are part of the Preferred Provider Plan network that applies if you live within California. However, if you are living or traveling outside of California (but within the United States) you will need to enter the state in which you are located in order to find names and locations of **BlueCard PPO** Participating Hospitals and Participating Providers.

You can also use the website as a guest but you must enter the correct Preferred Provider Plan network in order to find the correct Participating Hospitals and Participating Providers that are part of the Fund’s Preferred Provider Plan network.

Value-Based Site Program

The Value-Based Site program provides you with Hospital alternatives for obtaining covered services in connection with any of the surgical procedures where **Covered Expenses** for **Hospital charges** have been limited to a Maximum Plan Allowance (MPA) – refer to page 54.

If you live within California, and if you or your eligible Dependents decide not to use a Value-Based Site for any surgical procedure where **Hospital charges** have been limited to a MPA, all **Hospital charges** over the MPA will be your responsibility in addition to the Deductible and the Plan’s usual coinsurance and will not count toward the annual Plan Year Out-of-Pocket Maximum.

Exceptions to Value-Based Site

If you do not have access to a Value-Based Site or if services cannot be obtained at a Value-Based Site within a reasonable time or travel distance; or if the quality of services could be compromised by using a Value-Based Site, the MPA for **Hospital charges** in connection with total routine hip or knee replacement, arthroscopy, cataract or colonoscopy procedures **may not apply**.

For Arthroscopy, Cataract or Colonoscopy Procedures

Value-Based Sites are Ambulatory Surgical Centers (ASC) providers that are part of the Fund’s Preferred Provider Plan network.

For Routine Total Hip or Knee Replacement Surgery

Value-Based Sites are “**Designated**” Hospitals throughout California that are part of the Fund’s Preferred Provider Plan network. You may see a list of Value-Based Sites on the Trust Funds’ website but you are cautioned to always verify that the location is still a Value-Based Site before you select that Hospital. Your surgeon must also be able to perform surgery at that Hospital.

Travel-Related Expenses If You Use a Designated Hospital

NOTE

This benefit may be considered as taxable income by the IRS.

If you must travel 50 or more miles from your home to a Designated Hospital (a Value-Based Site) for routine total hip or knee replacement surgery, you may be entitled to reimbursement of up to \$750 for travel-related expenses. Call the Trust Fund Office for further information.

Hospital Emergency Room Versus Urgent Care Center


Your primary doctor is the best place to start when you are sick. Your doctor knows your health history, including any underlying conditions you may have. When you visit your doctor for an illness or injury, they can make informed choices about your treatment and necessary tests. But what if you get sick or injured when your doctor's office is closed?

Hospital emergency rooms (ER) are the best place for treating severe and life-threatening conditions. They have the widest range of services for emergency after-hours care, including diagnostic tests and access to specialists. However, this specialized care also makes it the most expensive type of care and often requires a long wait to be treated. Patients typically spend 3.2 hours on average in the ER, including the actual doctor consultation and any treatment. ER visits are about **six times more expensive** than comparable care in a physician’s office. If your condition is **NOT** life-threatening but you need care right away, using an Anthem Blue Cross Urgent Care Center instead of the ER may be the better choice for you.

The purpose of an Urgent Care Center is to fill in the gaps between your primary care physician visits and the ER. Urgent Care Centers offer the following advantages:

- Convenient locations
- Open after normal business hours, including evenings and weekends
- No appointment required
- Shorter wait times
- Lower charges (means lower Coinsurance to you and the ER Copayment will not apply)

URGENT CARE CENTER LOCATION SEARCH

Anthem Blue Cross
 www.anthem.com/ca

The important thing is to use your best judgment when choosing where to get care. It's a good idea to know where the closest Participating Hospitals and Urgent Care Centers are in your area. So if you need immediate care, you'll already know where to go.

Case Management Program

Case management is a program designed to assist you or an eligible Dependent in making important decisions concerning your health care. Anthem Blue Cross, the organization currently performing Utilization Review (UR), also provides case management for the Fund which includes Hospice Care and Home Health Care.

Case management typically involves you, your family, health care providers, and the Fund in assessing and coordinating the best possible care for each situation. This process can help move you or your eligible Dependent from an acute care Hospital setting to an alternative, more comfortable and efficient setting as soon as it is medically safe to do so. Case management professionals can arrange for your care, nursing and equipment needs at the time of discharge from an acute care Hospital. This is possible because Anthem Blue Cross has the ability to select cases that may benefit from case management since its staff reviews and monitors Hospital admissions through the UR program.

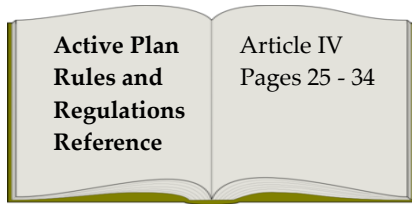
Hospice Care is designed to provide pain control and symptoms relief for terminally ill patients at an approved or licensed hospice facility or at the patient's home. Covered services include, but not limited to, nursing visits, social services, home health aide and medical supplies. The Plan does not provide benefits for costs of food, transportation (other than ambulance), financial or legal counseling or services provided by family members or friends of the patient.

Lower Benefits for Non-Participating Hospitals and Providers

When you use a **Non-Participating** Hospital or Provider, you will generally experience a higher share of costs for Covered Expenses:

1. You will not receive lower negotiated rates for Covered Expenses.
2. You will, generally, pay a higher coinsurance for Covered Expenses.
3. You will be responsible for paying all charges that exceed the Plan's Allowed Charge or Maximum Plan Allowance (MPA).
4. Any Copayments, Deductible and/or coinsurance you pay for Covered Expenses will not count toward your Plan Year Out-of-Pocket Maximum.

Comprehensive Hospital-Medical Benefits



Copayment


A Copayment is the flat dollar amount you pay for a Covered Expense and is required before the Plan Year Deductible and the coinsurance are applied. Most providers will ask you to pay the Copayment at the time of the service.

The following Covered Expenses have a Copayment:

1. Physician Office Visits: \$15 Copayment per visit
The Physician Office Visit Copayment does not apply to: Chiropractic visits, Routine Physical Examinations, Well Baby visits and Physician consultations.
2. Electronic (E-Visit) or Online Medical Evaluation: \$10 Copayment per visit
3. Outpatient Hospital Emergency Room Services:
\$25 Copayment each visit to a Participating Hospital
\$50 Copayment each visit to a Non-Participating Hospital

URGENT CARE CENTERS

Use a Participating Urgent Care Center instead to avoid paying a Copayment.

 www.anthem.com/ca

The Copayment does not apply if:

- You are admitted to the Hospital as a bed patient where you will stay overnight
- You are transported to the emergency room by paramedic intervention
- You are dead upon arrival in the emergency room
- You die while being treated in the emergency room

Deductible

The Deductible is the annual amount you pay for Covered Expenses before the Plan begins paying benefits and is applied after any applicable Copayment. The Deductible period begins March 1 and ends February 28 – the entire Plan Year period.

Carryover

Any part of the Deductible that you or your Dependents satisfy during the last three months (December, January and February) of the current Plan Year will count towards the Deductible for the next Plan Year period.

Deductible Amount

The amount of the Deductible you will pay per Plan Year is as follows:

- \$150 per individual
- \$450 maximum per family

The family Deductible limits the amount of Deductible expense you and your Dependents have to pay during any one Plan Year for Covered Expenses. If there are 4 or more persons in your family, the family Deductible can be satisfied in any combination up to a combined amount of \$450. **However, no one person can satisfy more than the individual amount.** See the example below.

Examples - How the Deductible is Applied

\$150 per individual/\$450 family maximum per Plan Year				
Size of Family	Participant Only	Participant plus Spouse	Participant, Spouse plus 1 Child	Participant, Spouse plus 2 or more Children
Participant	\$150	\$150	\$150	Up to \$150 per person but not to exceed \$450 combined
Spouse		\$150	\$150	
Child 1			\$150	
Child 2				
Child 3				
TOTAL	\$150	\$300	\$450	\$450

Exceptions

The Deductible does not apply to the following Covered Expenses:

- Hospital or Skilled Nursing Facility charges for inpatient services
- Routine Physical Examinations for the Participant, Dependent spouse or Domestic Partner
- Well Baby visits for Dependent children 24 months of age or older
- E-Visit through LiveHealth Online Services
- Prescription Drugs

Coinsurance

The term “coinsurance” means an amount represented as a percentage that the Fund pays and that you pay on most Covered Expenses. If a Covered Expense is subject to a Copayment and/or Deductible amount, the coinsurance is applied last to the remaining balance.

For Participating Hospital or Provider Charges

EXCEPTIONS

The Fund will pay 100% of the negotiated rate rather than 90% for:

1. An office visit by a Participating Physician.
2. An E-Visit or Online Medical Evaluation.

The coinsurance level is 90/10 when you use a Participating Hospital or Participating Provider. This means the Fund pays 90% of the negotiated rate after any Copayment and/or Deductible is applied. You pay 10% of the negotiated rate plus any applicable Copayment and/or Deductible.

For Non-Participating Hospital or Provider Charges

The coinsurance level is 70/30 when you use a Non-Participating Hospital or Non-Participating Provider. This means the Fund pays 70% of the Allowed Charges after any Copayment and/or Deductible is applied. You pay 30% of the Allowed Charges plus any applicable Copayment and/or Deductible.

EXCEPTIONS

The Fund will pay 90% of the Allowed Charges rather than 70% if:

1. You used professional ambulance services for Emergency Services.
2. You received emergency room treatment from a Physician at a Participating Hospital's emergency room.

Inpatient Hospital Services

The Plan will pay benefits for inpatient hospital services if you are confined in a Hospital or Skilled Nursing Facility (SNF) for treatment of or in connection with an illness, injury, pregnancy, mental health or psychiatric disorder, chemical dependency or substance abuse. Covered services include but not limited to room and board, diagnostic lab tests and x-rays, ancillary charges, drugs and blood transfusions. Charges for personal items such as guest meals or use of a private room not ordered by a Physician are not covered.

For Participating Hospital Charges

The coinsurance level is 90/10 of the first \$10,000 of the negotiated rate when you are admitted to a Participating Hospital or SNF. This means the Fund pays 90% of the first \$10,000 of the negotiated rate and 100% of the remaining amount. You pay 10% of the negotiated rate but not to exceed \$1,000.

For Non-Participating Hospital Charges

EXCEPTIONS

The Fund will pay 90% of Covered Charges rather than 70% if:

1. You are admitted due to an emergency or life-threatening condition.
2. You live outside the Plan's Preferred Provider Service Area.

The coinsurance level is 70/30 of the first \$10,000 of "Covered Charges" when you are admitted to a Non-Participating Hospital. This means the Fund pays 70% of the first \$10,000 of Covered Charges and 100% of the remaining amount. You pay 30% of the Covered Charges but not to exceed \$3,000. However, you will also be required to pay any amounts that exceed the Covered Charges limit and any non-covered charges such as personal items, for example: guest meals or used of a private room for personal convenience.

The term “Covered Charges” means (1) 100% of the hospital’s lowest rates for semi-private room or intensive care unit (or critical care unit) or (2) 80% of the hospital’s lowest rate for private room.

Covered Expenses

The term “Covered Expenses” refers to hospital and medical services that are covered by the Plan, subject to all other Plan provisions and must be determined to be Medically Necessary.

EXCLUSIONS

Refer to page 70 for list of expenses that are not covered by the Plan.

Below is a list of Covered Expenses (in alphabetical order) under your Plan. Additional Covered Expenses are listed in the Maximum Plan Allowance (MPA) section on page 54.

1. Acupuncture services by a licensed acupuncturist necessary to treat an injury or pain.
2. Ambulance services that requires professional paramedic support from the place where you are injured or stricken by illness to or from a Hospital or Physician’s office. Air ambulance transportation is covered only if Medically Necessary to avoid the possibility of serious complications or loss of life.
3. Ambulatory Surgical Center (ASC) services. For arthroscopy, cataract and colonoscopy procedure and charges by a Non-Participating ASC, refer to MPA section on page 54.
4. Anesthesia and its administration.
5. Blood and blood products.
6. Chemotherapy prescribed by a Physician.
7. Consultations with a Physician including second surgical opinions.
8. Contraceptive implants, injections, devices which are prescribed by a Physician or surgical procedures resulting in voluntary infertility (including but not limited to sterilization or a vasectomy).
9. CT or PET Scans and magnetic resonance imaging (MRI) prescribed by a Physician for treatment or diagnostic purposes.
10. Dental services for the following:
 - Treatment to alleviate the damage to broken or injured teeth which is the result of an accidental bodily injury (no payment will be made for the replacement of teeth, in whole or in part).
 - Medically Necessary surgery not covered under the Fund’s dental care benefits.

11. Durable Medical Equipment (DME) prescribed by a Physician including, but not limited to hospital beds, wheelchairs, oxygen and prosthetic devices. The Plan will not pay more than the purchase price for rental charges of a DME.
12. E-visit or online medical evaluation by a Physician through LiveHealth Online Services. LiveHealth Online is an Internet based service that allows you to personally interact with a doctor to address non-emergency health concerns.
13. Gender identity disorder or gender dysphoria treatment and services including gender reassignment surgery if approved in advance as Medically Necessary.
14. Home Health Care services but only upon referral and approval by the Plan's Professional Review Organization (PRO).
15. Hospice Care services but only upon referral and approval by the Plan's PRO.
16. Hospital outpatient emergency room services.
17. Hospital outpatient services. Covered services include but not limited to operating room, recovery room, diagnostic lab tests and x-rays, ancillary charges and drugs. For arthroscopy, cataract and colonoscopy procedure, refer to MPA section on page 54.
18. Immunizations, injections and inoculations for adults and children.
19. Intravenous therapy on an outpatient basis which is authorized by and under the direct supervision of a Physician for the treatment of an illness that would otherwise require hospitalization.
20. Laboratory tests prescribed by a Physician for treatment or diagnostic purposes.
21. Mastectomy services, including reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance and prosthesis and treatment of physical complications of all states of mastectomy, including lymphedemas.
22. Mental health or psychiatric disorders including Medically Necessary services by a licensed psychiatrist, psychologist, licensed marriage or family therapist or counselor or licensed social worker.
23. Nursing services by a licensed nurse practitioner (NP), registered graduate nurse (RN) or licensed vocational nurse (LVN). Services by a certified nurse-midwife for obstetrical care are covered provided the midwife is under the supervision of a Physician.
24. Optometrist (eye doctor) services but only when providing Medically Necessary treatment to the eye that is not covered under the vision care benefits.

25. Physical or occupational therapy services provided by a registered physical therapist (RPT) or occupational therapist not related to you and prescribed by a Physician.
26. Physician charges for office, emergency room or urgent care visits; medical or surgical services. Services by a licensed Physician Assistant (PA) are covered provided the PA is under the supervision of a Physician and billed under the Physician tax identification number.
27. Radiation therapy prescribed by a Physician.
28. Speech therapy prescribed by a Physician to restore normal speech due to stroke or to correct dysphasic swallowing defects due to an illness, injury or surgical procedure.
29. Substance abuse rehabilitation or chemical dependency treatment.
30. Surgical dressings, splints, casts and other devices for the treatment of burns or the reduction of fractures and dislocations.
31. Weight Loss Surgery (Bariatric surgery or gastric bypass). You **MUST** use a Blue Distinction® Center for Bariatric Surgery that is part of the Fund's Preferred Provider Plan network otherwise the Hospital charges **will not be covered**. All weight loss surgical procedures must also be pre-authorized by Anthem Blue Cross.

PROVIDER SEARCH

Anthem Blue Cross



1-800-274-7767

Weight-loss surgery, in connection with the treatment of morbid obesity, is covered if your Body Mass Index (BMI) is greater than 35 **and** complicated by any of the following:

- Life-threatening cardiopulmonary conditions;
- Difficulty controlling diabetes mellitus or hypertension;
- End stage renal disease;
- Severe sleep apnea (documented by a sleep study);
- Severe lower extremity edema with ulceration;
- Symptomatic degenerative joint disease, resulting in ambulatory difficulties (cane, walker, wheelchair); **or**
- Stress incontinence with gynecologic abnormalities.

Only one of the following weight loss surgical procedures will be covered in a lifetime:

- Roux-en Y gastric bypass
- Gastric stapling or banding
- Biliopancreatic bypass

32. X-rays prescribed by a Physician for treatment or diagnostic purposes.

Maximum Plan Allowance (MPA)

The Fund limits the dollar amount allowed for certain Covered Expenses. The term used for a Covered Expense that has a maximum dollar amount allowance is “Maximum Plan Allowance (MPA)”. The regular coinsurance for some Covered Expenses will apply first as outlined in the Coinsurance section on page 49 but if the Covered Expense is subject to a MPA, the Fund will not pay more than the MPA.

You will be responsible for paying any charges that exceed the MPA in addition to any Copayment, Deductible and coinsurance. Charges that exceed the MPA do not count toward your Plan Year Out-of-Pocket Maximum - refer to page 58 - even if you used a Participating Hospital or Provider.

Routine Total Hip or Knee Replacement Surgery

Inpatient Hospital charges for routine total hip or knee replacement surgery at a Participating or Non-Participating Hospital are limited to the MPA if you live in California. The MPA only applies to Hospital charges and does not apply to the professional fees charged by the surgeon or any other non-Hospital related expenses in connection with the surgical procedure.

The illustration below indicates the difference in cost between a Value-Based Site “*Designated Hospital*” and a Participating Hospital that is **NOT** a *Designated Hospital*. Because actual billed charges and negotiated rates vary between different Participating Hospitals, the illustration is not based upon the actual billed charge or negotiated rate for any one provider.

A Participating Hospital that is a Value-Based Site <i>Designated Hospital</i>		A Participating Hospital that is NOT a Value-Based Site <i>Designated Hospital</i>	
Billed Charge	\$52,000	Billed Charge	\$65,000
Negotiated Rate	\$30,000	Negotiated rate	\$52,000
MPA	\$30,000	MPA	\$30,000
Amount over MPA	\$0	Amount over MPA	\$22,000
10% of \$10,000 (your coinsurance)	\$1,000	10% of \$10,000 (your coinsurance)	\$1,000
You owe over MPA	\$0	You owe over MPA	\$22,000
Total you owe	\$1,000	Total you owe (\$1,000 + \$22,000)	\$23,000

Outpatient Arthroscopy, Cataract or Colonoscopy Procedure

These procedures are limited to the MPA when performed at the outpatient department of a Hospital and **you live within California**.

When Hospital charges exceed the MPA, you are responsible for payment of all Hospital charges that exceed the MPA in addition to any Copayment, Deductible and coinsurance. Use a Value-Based Site instead if you live in California, i.e. an Ambulatory Surgical Center (ASC). The MPA only applies to Hospital charges and does not apply to the professional fees charged by the surgeon or any other non-Hospital related expenses in connection with the surgical procedure.

Where Covered Expenses for Hospital charges are limited to the MPA, and you live within California, you and your eligible Dependents are provided with alternative provider choices referred to as Value-Based Sites. Using these providers will save you money on your share of the cost.

The illustration below for an arthroscopy procedure demonstrates the difference in costs between what you can expect, when using an ASC instead of the outpatient surgical department of a Hospital— **because actual billed charges and negotiated rates vary between providers for the same services.**

Participating Value-Based Site Ambulatory Surgical Center (ASC)		Outpatient Surgical Department of a Participating Hospital	
Billed Charge	\$8,500	Billed Charge	\$11,500
Negotiated rate	\$6,000	Negotiated rate	\$9,500
MPA	\$6,000	MPA	\$6,000
Amount over MPA	\$0	Amount over MPA	\$3,500
You owe 10% of MPA	\$600	You owe 10% of MPA	\$600
You owe the amount over MPA	\$0	You owe the amount over MPA	\$3,500
Total you owe	\$600	Total you owe	\$4,100

Other Covered Expenses with MPA

The following Covered Expenses are also subject to a MPA:

1. Non-Participating Ambulatory Surgical Center (ASC) for outpatient services.
2. Chiropractic services such as manipulations, x-rays and laboratory test by a licensed chiropractor. Charges for supplies must be Medically Necessary and not for personal comfort of the Eligible Individual.
3. Hearing aid devices prescribed by a Physician. Repairs to or replacement of a hearing aid device that is lost, broken or stolen are not covered.
4. Well Baby visits for Dependent children older than 24 months of age, according to the schedule of the American Academy of Pediatrics.
5. Routine Physical Examinations for Participants, Dependent spouse or Domestic Partner.

Overview of Covered Expenses with MPA

Type of Covered Expense		MPA	Your Share
Hospital Charges	Inpatient routine total hip or knee replacement surgery	\$30,000	You pay all Hospital charges that exceed \$30,000
Hospital Charges	Outpatient arthroscopy procedure	\$ 6,000	You pay all Hospital charges that exceed \$6,000
	Outpatient cataract procedure	\$ 2,000	You pay all Hospital charges that exceed \$2,000
	Outpatient colonoscopy procedure	\$ 1,500	You pay all Hospital charges that exceed \$1,500
Routine Physical Exam or Well Baby*	Participant, Spouse or Domestic Partner	\$300 per exam	You pay all charges that exceed \$300
	Dependent Children	\$200 per exam	You pay all charges that exceed \$200
Chiropractor Charges*	Visits	\$40 per day 40 visits per Plan Year	You pay all charges that exceed \$40 per visit and 40 visits per Plan Year
	X-Rays	\$100 per Plan year	You pay all charges that exceed \$100
Hearing Aids*	Device	\$1,200 per ear Every 36 months	You pay all charges that exceed \$1,200
Ambulatory Surgical Centers	Non-Participating Ambulatory Surgical Center	\$500 per day	You pay all charges that exceed \$500 per day

* The Fund will pay 100% of the Allowed Charge or the MPA amount, whichever is less. Any amounts denied as over the MPA do not accumulate to your annual Out-of-Pocket maximum.

Utilization Review (UR) Requirement

Utilization Review (UR) is required for all overnight inpatient hospitalizations. Exception: Maternity admissions where the length of stay does not exceed 48 hours for a routine delivery or 96 hours for a caesarean section are not subject to this requirement. If a maternity stay exceeds these time frames, then a Concurrent or Retrospective Review is required.

There are three (3) different types of UR:

1. Pre-Admission Review: For all elective inpatient Hospital admissions.

Penalty - If you are admitted to a Non-Participating Hospital and a Pre-Admission Review is not obtained, you will be responsible for an additional coinsurance of 20% of the first \$10,000 of Covered Charges whether or not a Retrospective Review is obtained after you have been discharged and determined that your stay was Medically Necessary. The additional coinsurance will not count toward the Plan Year Out-of-Pocket Maximum.

2. Concurrent Review: For any ongoing inpatient Hospital admission.

3. Retrospective Review: After you have been discharged from the Hospital when there has been no Pre-Admission or Concurrent Review.

Professional Review Organizations (PRO)

PROs are companies under contract with the Fund that determine whether an inpatient Hospital confinement is Medically Necessary, including the number of authorized days and/or whether a proposed non-emergency outpatient service is Medically Necessary.

CONTACT INFO

Anthem Blue Cross



1-800-274-7767

Anthem Blue Cross is the Fund's PRO for Utilization Review (UR) for inpatient hospitalizations and for Pre-Authorization Review in connection with bariatric surgery procedures.

Remember, some Covered Expenses require that you obtain a UR, a Pre-Authorization Review, use a Participating Hospital or Participating Provider from the Fund's Preferred Provider Plan network or use a Value-Based Site if you live in California in order to receive full Plan benefits and limit your share of the cost for Covered Expenses.

Utilization Review Requirements Recap Chart

Type of Admission	Requirement
Schedule/Elective Non-Emergency	Anthem Blue Cross MUST approve your stay BEFORE you are admitted.
Emergency/Urgent	Anthem Blue Cross MUST be notified within 24 hours of your admission.
Childbirth	No UR is required if stay is less than: 48 hours for normal delivery or 96 hours for C-Section Delivery
Bariatric Surgery Gastric Bypass	ALL planned services MUST be approved by Anthem Blue Cross BEFORE you are admitted. In addition, an approved Center of Excellence must be used.
Any admission	When the Laborers Active Plan is the secondary payer of benefits for your eligible Dependent's hospital stay, UR is not required by this Plan.

Plan Year Out-of-Pocket Maximum

An important cost-saving feature of the Plan is the annual Plan Year **Out-of-Pocket Maximum**. The Plan Year Out-of-Pocket Maximum limits *your share of cost* each Plan Year for health care expenses.

Individual and Family Out-of-Pocket Maximum

The maximum out-of-pocket expense that you will pay for Covered Expenses per Plan Year is as follows:

- \$3,000 per individual
- \$6,000 per family

Once the Plan Year Out-of-Pocket Maximum has been reached, either individually or as a family, you will have no further Copayments, Deductible or coinsurance for the remainder of the Plan Year when you use Participating Hospitals or Providers. The Fund will begin paying 100% of the Allowed Charge for the remaining of the Plan Year.

What Counts Toward the Plan Year Out-of-Pocket Maximum

Not all out-of-pocket expenses you pay for Covered Expenses will count towards your Plan Year Out-of-Pocket Maximum. Only charges by **Participating Hospitals and Providers** where you incurred out-of-pocket expenses will count towards your Plan Year Out-of-Pocket Maximum. The out-of-pocket expenses that will count are as follows:

1. Physician Office Visit and Emergency Room Copayments
2. Deductible
3. Coinsurance (Exception: If you are admitted to a Non-Participating Hospital due to a serious or life-threatening emergencies, your coinsurance or out-of-pocket expenses will count towards your Plan Year Out-of-Pocket Maximum)


What Does Not Count

1. Physician Office Visit and Emergency Room Copayments, Deductible and coinsurance when you use a Non-Participating Hospital or Provider.
2. Copayments for LiveHealth Online.
3. All charges that exceed the Plan's Maximum Plan Allowance (MPA) for certain Covered Expenses regardless of the type of provider you used (Participating or Non-Participating Hospital or Provider).
4. All charges that exceed the Plan's Allowed Charge when you use a Non-Participating Hospital or Provider.
5. All charges that exceed the Plan's Covered Charges for inpatient admission to a Non-Participating Hospital.

6. Services and supplies that are not covered or allowed by the Plan regardless of the type of provider you used (Participating or Non-Participating Hospital or Provider).
7. Penalties for non-compliance with the Plan's Utilization Review (UR) requirements.
8. All out-of-pocket expenses for medications or prescription drugs that are provided under the separate Prescription Drug program through OptumRx.
9. All out-of-pocket expenses for dental and vision care that are provided under the separate dental and vision care programs.

Overview of How Your Annual Out-of-Pocket Maximum Accumulates

The chart below illustrates how the \$3,000 Plan Year Out-of-Pocket Maximum accumulates. Because the "Annual Out-of-Pocket Balance" through Claim #8 is near \$3,000, the "Total You Pay" amount for Claim #9 is adjusted from \$800 to \$710 so that the "Annual Out-of-Pocket Balance" does not exceed \$3,000. After the \$3,000 maximum is reached, Claims #10 and #11 are paid at 100%.

Claim #	Allowed Amount	Less Copayment Amount*	Less Deductible Amount*	Balance Allowed Amount	Less Your Coinsurance*	Plan Pays	Total You Pay	Annual Out-of-Pocket Balance*
1 Emergency Room	\$2,000	\$25	\$150	\$1,825	\$182.50	\$1,642.50	\$357.50	\$357.50
2 Physician Office Visit	\$200	\$15		\$185		\$185	\$15	\$372.50
3 Inpatient Hospital	\$15,000			\$15,000	\$1,000	\$14,000	\$1,000	\$1,372.50
4 Surgeon	\$4,000			\$4,000	\$400	\$3,600	\$400	\$1,772.50
5 Anesthesia	\$1,200			\$1,200	\$120	\$1,080	\$120	\$1,892.50
6 Emergency Room	\$500	\$25		\$475	\$47.50	\$427.50	\$72.50	\$1,965
7 X-rays	\$750			\$750	\$75	\$675	\$75	\$2,040
8 MRI	\$2,500			\$2,500	\$250	\$2,250	\$250	\$2,290
9 Outpatient Hospital	\$8,000			\$8,000	\$800	\$7,200	\$800	\$3,090
Claim #9 Coinsurance is reduced as the Annual Out-of-Pocket Balance has exceeded the \$3,000 maximum					\$710	\$7,290	\$710	 \$3,000
10 Lab Tests	\$500			\$500		\$500	\$0	\$3,000
11 Physician Office Visit	\$150			\$150		\$150	\$0	\$3,000

* Your cost sharing that count towards the Plan Year Out-of-Pocket Maximum are shaded in green.

The Future Moms' Program

CONTACT INFO

Anthem Blue Cross



1-866-664-5404

Future Moms' program is for female Participants or the female spouse or Domestic Partner of the Participant. Dependent children are not covered for pregnancy-related expenses under the Direct Payment Plan.

The program is designed to identify risks early in a pregnancy and to provide the quality care needed to have a successful pregnancy and deliver a healthy baby. Delivering a healthy baby usually will result in lower out-of-pocket costs for you and can avoid high risks pregnancies which can result in early or premature delivery requiring more expensive medical services and longer hospital stays for the newborn.

Call the Future Moms' program as soon as you know you are pregnant but no later than the first trimester (12 weeks) to register with the program. A registered nurse will explain the program benefits to you and help you get started. Some of the features of the program include:

- A toll-free telephone number where you can speak with a nurse coach anytime, day or night, about your pregnancy.
- Screenings to see if you might be at risk for depression or early delivery.
- Useful tools to help you, your doctor and your Future Moms' nurse coach manage your pregnancy.

Reminder: Actions to Take to Lower Your Out-of-Pocket Costs

- Always use Participating Hospitals, Participating Providers and Value-Based Site Providers for covered health care services.
- Always obtain a UR through the PRO for any type of admissions to certify your entire stay as Medically Necessary.
- Always obtain a Pre-Authorization Review through the PRO when one is required so you do not pay the extra coinsurance.
- Enroll and participate throughout your pregnancy in the Future Moms' program in order to have useful tools to use throughout your pregnancy and avoid higher costs due to high-risk pregnancy.

Payment of Benefits

Claims must be received by the Fund's designee Anthem Blue Cross (ABC), or in the case of the BlueCard PPO national network, the host plan, as soon as possible but in no event later than one year from the date of services. Claims should not be sent to the Trust Fund Office. If you do send them to the Trust Fund Office, the processing of the Claims will be delayed.

Once a Claim is paid or denied by the Fund, the Fund will send you an Explanation of Benefits (EOB) notice. The EOB provides you with an overview of how the Claim was processed – specifically how the benefits were calculated or if denied, the reason for the denial. The EOB will show the Claim's "line level" first which includes all services billed for each procedure. The bottom section of the EOB will show the Claim's "total level" which includes the amount for which you are responsible and the Fund's total payment. Below is a list of the information that is shown on an EOB.

1. The date of service, procedure code or description, and the amount billed;
2. The Allowed Amount by the Plan;
3. Your share of the cost, if they were applied: Copayment, Deductible, coinsurance and/or over the MPA, and if any, excluded items and the reason for the exclusion;
4. The Plan's share of the cost (the difference between #2 and #3 above);
5. Any adjustment such as other insurance payment or previous payment;
6. The amount for which you are responsible and the Fund's payment amount to the provider.

Benefits Required by Law

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurers may not restrict benefits for any Hospital length of stay for the mother or newborn child to less than 48 hours following a normal delivery, or to less than 96 hours following a caesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the 48 hours, or 96 hours stay as applicable.

Women's Health and Cancer Rights Act (WHCRA)

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must also provide benefits for reconstructive surgery, in a manner determined in consultation with the attending physician and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the Plan's Copayment, Deductible and coinsurance provisions.

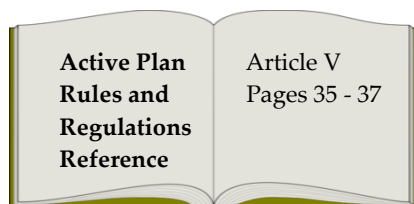
In addition to the information concerning Women's Health and Cancer Rights Act (WHCRA) appearing in this booklet, the Plan is required to mail an annual notice to remind you that breast cancer patients who elect to have reconstructive surgery in connection with a mastectomy have certain protections under federal law.

Overview of Covered Expenses and Benefit Application

Type Of Service	Copayment Amount	Deductible Yes or No	Plan Allowed Charge % Coinsurance		Maximum Plan Allowance (MPA) OR Remarks/Notes
			In-Network	Out-of-Network	
Acupuncture	\$0	Y	90%	70%	Must be pain related condition
Ambulance	\$0	Y	90%	90%	N/A
Ambulatory Surgical Center	\$0	Y	90%	70%	\$500 for Out-of-Network
Anesthesia	\$0	Y	90%	70%	N/A
Blood/Blood Plasma	\$0	Y	90%	70%	N/A
Chiropractic Visit	\$0	Y	100%	100%	\$40 per Visit 20 Visits per Plan Year
Chiropractic X-Rays	\$0	Y	100%	100%	\$100 per Plan Year
Consultation (by a specialist)	\$0	Y	90%	70%	N/A
Durable Medical Equipment	\$0	Y	90%	70%	Must be prescribed by a Physician
Emergency Room Physician	\$0	Y	90%	70%*	* 90% If PPO Hospital is used
Hearing Aids	\$0	Y	90%	70%	\$1,200 per ear/device per 36 months Must be prescribed by a Physician
Home Health Care	\$0	N	90%	Not Covered	Must be pre-approved by Anthem Blue Cross
Hospice Care	\$0	N	90%	Not Covered	Must be pre-approved by Anthem Blue Cross
Hospital Emergency Room	\$25 PPO \$50 Non-PPO	Y	90%	70%	Copayment is waived under certain circumstances
Hospital/SNF Inpatient 1 st \$10,000 \$10,000 Thereafter	\$0	N	90% 100%	70%* 100%	* 90% If emergency admission or you live outside the PPO area 1) Subject to \$30,000 MPA for routine total hip or knee replacement. 2) Gastric Bypass subject to preapproval by Anthem Blue Cross and you MUST use a Blue Distinction Center only.
Hospital Outpatient	\$0	Y	90%	70%	Subject to MPA for procedure: Arthroscopy - \$6,000 Cataract - \$2,000 Colonoscopy - \$1,500
Immunizations / Injections	\$0	Y	90%	70%	N/A
Lab Tests	\$0	Y	90%	70%	N/A
LiveHealth Online Visit	\$10	N	100%	N/A	N/A
Office Visit	\$15	Y	100%	70%	N/A
Physical Exam (Adults)	\$0	N	100%	100%	\$300 per exam
Physical/Occupational Therapy	\$0	Y	90%	70%	Must be prescribed by a Physician
Speech Therapy	\$0	Y	90%	70%	Stroke or swallowing defects only
Surgery (surgeon or assistant)	\$0	Y	90%	70%	N/A
X-Rays / CT Scans / MRI	\$0	Y	90%	70%	N/A
Well Baby (Older Than 2 Years)	\$0	N	100%	100%	\$200 per exam

For Participating Providers only – the Plan will start paying 100% rather than 90% once you meet your annual Out-of-Pocket Maximum of \$3,000 or \$6,000 for family.

Prescription Drugs Benefit



Glossary of Terms

“Contracting Pharmacy” means a pharmacy which has a contract with the Pharmacy Benefit Manager (PBM) to provide prescription Drug services to Eligible Individuals.

“Formulary” means a preferred list of quality and cost-effective brand-name medications established by the PBM.

KAISER MEMBERS

This entire section only applies to Direct Payment Plan Participants

“Non-Contracting Pharmacy” means a pharmacy that does not have a contract with the Pharmacy Benefit Manager (PBM) to provide prescription Drug services to Eligible Individuals.

“Pharmacy Benefit Manager (PBM)” means the company under contract with the Laborers Health and Welfare Trust Fund for Northern California and who administers the Direct Payment Plan’s prescription Drug benefits. The Fund’s PBM is OptumRx.

“Specialty Pharmacy” means a pharmacy that provides medications that may be self-administered or administered at a Physician’s office to treat a chronic or acute illness. The Specialty Pharmacy manages specialty medications that often times are not available at the local retail Contracting Pharmacy because they may require special handling and storage. The Specialty Pharmacy is through the PBM.

The Pharmacy Benefit Manager (PBM)

Most large chain pharmacies are in the OptumRx network but so are many other retail pharmacies throughout the United States. However, **BEFORE** you have your prescription filled, you should always ask the pharmacy if they are a Contracting Pharmacy with OptumRx. You can also register with a user name and password on the OptumRx website to check for contracting pharmacies.

Maintenance Medications

Maintenance medications are medications you take on a regular basis.

When you purchase maintenance medications from a retail Contracting Pharmacy, beginning with the 4th fill **of any one medication**, the usual copayment **will double for the same 30-days’ supply**. You may wish to consider using the Mail Service Pharmacy through OptumRx for additional refills.

Mail Service Pharmacy

If you wish to take advantage of the Mail Service Pharmacy, after your 3rd fill at the retail Contracting Pharmacy and at least three weeks prior to the 4th fill, you should ask your prescribing Physician to call or fax your prescription order to OptumRx. You should then follow up with a telephone call to OptumRx to tell them how you wish to pay for your share of the cost.

Generic Versus Brand Name Drugs

By law, both generic and brand name medications must meet the same standards for safety, purity and effectiveness. However, generic medications, on average, are about half the cost of brand-name medications. When you choose a cheaper generic medication over brand-name medication, in addition to paying a lower copayment, your choice also saves the Trust Fund money.

Always ask if there is a generic equivalent for the prescriptions you need filled. You can either ask your Physician before he writes your prescription or the pharmacist at the retail store where you purchase the medication. If there is no generic version available, you will only pay the copayment for the brand-name drug.

GENERIC DRUG IS AVAILABLE

In addition to your copayment for brand-name drug, you are also responsible for the price difference between the generic and brand-name if you choose the brand-name drug over the generic version.

Formulary Versus Non-Formulary Brand-Name Drugs

Both Formulary and Non-Formulary brand-name medications are covered by the Plan but your copayments are different and are higher than your copayment for generic drugs.

Covered Charges

The following drugs or medications are covered by the Plan:

- Drugs prescribed by a Physician licensed by law to administer or prescribe Drugs.
- Drugs, insulin or insulin injection kits which are supplied:
 - to the patient in the Physician's office, and for which a charge is made separately from the charge for any other item or expense, **or**
 - by a Hospital for use outside of the Hospital provided that the Drugs are prescribed by a Physician licensed by law to prescribe or administer Drugs.
- Compounding dermatological preparations prescribed by a Physician.
- Therapeutic vitamins, cough mixtures, antacids, eye and ear medications prescribed by a Physician for the treatment of a specific illness or complaint (you must have a prescription from your Physician).

- Self-administered oral or injectable medications to treat a chronic or acute condition, which can safely be administered in the patient's home. If the medication is included on the Plan's list of specialty medications and requires ongoing clinical supervision, the medications must be obtained from and distributed under a program managed by the Plan's Specialty Pharmacy. Self-administered injectables, such as insulin and Imitrex® are not specialty medications requiring distribution from the Fund's Specialty Pharmacy; these can be obtained from a retail Contracting or Non-Contracting Pharmacy.
- The following injectable medications: Ana-Kits, Epi-Pens, Glucagon and Imitrex®.

Excluded Drugs

The Plan will not pay for:

- Drugs taken or administered while a patient is in a Hospital (covered as part of the Hospital inpatient or outpatient charges).
- Patent or proprietary medicines not requiring a prescription, **except** insulin and those over-the-counter Drugs prescribed (require a prescription) by a Physician.
- Appliances, devices, bandages, heat lamps, braces or splints (may be a Covered Expense under the Comprehensive Hospital-Medical Benefits).
- Multiple non-therapeutic vitamins, cosmetics, dietary supplements, health and beauty aids.
- Charges for prescriptions in excess of a 30-days' supply at a Retail pharmacy or a 90-days' supply from the Mail Service Pharmacy.

Non-Contracting Pharmacy Reimbursement

If you use a Non-Contracting Pharmacy when purchasing a Covered Charge Drug, you must pay the full cost of your medications at the time of purchase. You will then need to file a Claim with OptumRx for reimbursement. Reimbursement will be based on the contract rate that would have been paid to a Contracting Pharmacy – see Copayments below. In most cases, you will pay a higher share of the cost for Covered Charges when you use a Non-Contracting Pharmacy.

Copayments

If you purchase any of the items listed under Covered Charges, the Fund will pay the amount described below less your share of the cost. Your cost will include the copayment and if applicable, the price difference between the generic drug and brand-name drug.

Contracting Retail Pharmacy

If the prescription Drug is purchased at a retail Contracting Pharmacy, the Fund will pay the Contracting Pharmacy for up to a 30-day supply per prescription as follows:

CONTACT INFO

Pharmacy stores list



1-800-797-9791



www.optumrx.com

1. For generic Drugs, the cost of the prescription less a copayment of \$10 **for the initial fill plus the first 2 refills.**
2. For Formulary brand-name Drugs, **if a generic Drug is available**, the cost of the prescription less (a) a copayment of \$20 **plus** (b) the difference in price between the generic and the Formulary brand-name Drug **for the initial fill plus the first 2 refills.**
3. For Formulary brand-name Drugs, **if a generic Drug is not available**, the cost of the prescription less a copayment of \$20 **for the initial fill plus the first 2 refills.**
4. For non-Formulary brand-name Drugs, **if a generic Drug is available**, the cost of the prescription less (a) a copayment of \$30 **plus** (b) the difference in price between the generic and the non-Formulary brand-name Drug **for the initial fill plus the first 2 refills.**
5. For non-Formulary brand-name Drugs, **if a generic Drug is not available**, the cost of the prescription less a copayment of \$30 **for the initial fill plus the first 2 refills.**

If you continue to have the prescription Drug filled at a retail Contracting Pharmacy after **the initial fill plus the first 2 refills**, the copayment amounts described in 1 to 5 above will double.

Mail Service Pharmacy

If the prescription Drug is purchased through the mail service Contracting Pharmacy, the Fund will pay the Contracting Pharmacy for up to a 90-day supply per prescription as follows:

CONTACT INFO

Mail Service



1-800-834-3773



www.optumrx.com

1. For generic Drugs, the cost of the prescription less a copayment of \$20.
2. For Formulary brand-name Drugs, **if a generic Drug is available**, the cost of the prescription less (a) a copayment of \$40 **plus** (b) the difference in price between the generic and the Formulary brand-name Drug.
3. For Formulary brand-name Drugs, **if a generic Drug is not available**, the cost of the prescription less a copayment of \$40.
4. For non-Formulary brand-name Drugs, **if a generic Drug is available**, the cost of the prescription less (a) a copayment of \$60 **plus** (b) the difference in price between the generic and the non-Formulary brand-name Drug.

5. For non-Formulary brand-name Drugs, if a generic Drug is not available, the cost of the prescription less a copayment of \$60.

Overview of Copayments

Type of Drugs	Contracting Pharmacy		Mail Service	Non-Contracting Pharmacy
	Copayment for 30-days' supply 1 st , 2 nd & 3 rd fill	Copayment for 30-days' supply 4 th fill or after*	Copayment for 90-days' supply	
Generic Drugs	\$10	\$20	\$20	** You pay the full cost at the pharmacy and submit a Claim to OptumRx. You will be reimbursed based upon the contract rate for a Contracting Pharmacy less the applicable copayment and other costs (see * and **)
Formulary Brand-Name	\$20	\$40	\$40	
	**If a generic drug equivalent is available: You pay the Copayment above plus the difference in price between the generic version and the Formulary brand-name.			
Non-Formulary Brand-Name	\$30	\$60	\$60	
	**If a generic drug equivalent is available: You pay the Copayment above plus the difference in price between the generic version and the Non-Formulary brand-name.			

* Beginning with the 4th fill of your generic or brand-name drug, your copayment will double for the same 30-days' supply if you continue purchasing the drug at a retail pharmacy. Make sure that you start using the Mail Service especially for Covered Charges that you take on an ongoing basis (maintenance medications) after the 3rd fill to avoid paying double the copayment. However, you are free to start using the Mail Service earlier than the 4th fill.

To save money and avoid making multiple trips to your retail pharmacy store, you may start using Mail Service for your 1st, 2nd or 3rd fill. You can receive up to a 90-days' supply of your medication by using Mail Service (that is 3 times the Plan's 30-days' supply limit for purchases at retail pharmacy stores) and the copayment is only double (not 3 times).

Third Party Liability

Active Plan
Rules and
Regulations
Reference

Article VII
Section 8
Page 44

If you or an eligible Dependent suffers an injury or illness that was caused by a third party, you must agree to pursue your claim against the responsible third party.

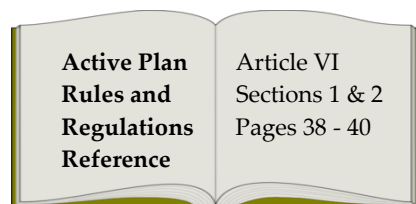
Before the Plan pays for any Covered Expenses in connection with that illness or injury, you or your eligible Dependent, must agree, **in writing**, to reimburse the Fund for the benefits paid on your behalf. This reimbursement will come from the money received as a result of pursuing a claim against a third party or any insurance company.

If you fail to complete the required documents or cooperate with the Board in pursuing the responsible third party, your Claim for benefits may be denied. Under the reimbursement agreement, the Fund has an automatic equitable lien against any recovery you receive from the responsible third party. If you fail to honor that lien or impair the Fund's right to recover from the money you receive, the Fund has the right to file suit in federal court to recover the amount of the benefits paid on your behalf. Your obligation to reimburse the Fund will arise if you receive money by way of a judgment, arbitration award, settlement or otherwise in connection with, or arising out of, any claim for or your right to damages regardless of how classified, for your injury or illness for which a third party is responsible. This includes payments from the third party, the third party's insurer or other indemnitor or from your uninsured or under-insured motorist coverage. In addition, the reimbursement to the Fund will not be subject to the common fund doctrine, the make-whole doctrine and any reduction based on comparative fault nor will the characterization of your damages impair or hinder the Fund's right to reimbursement.

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This section only
applies to Direct
Payment Plan
Participants.

Exclusions, Limitations and Reductions



The Fund will not provide benefits for **charges, services, treatment or supplies** related to or in connection with the items listed below. The Fund will also not pay for charges that are not Medically Necessary.

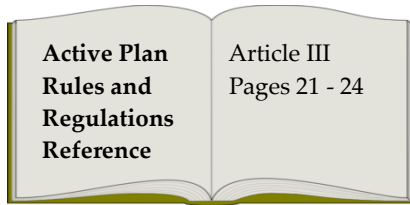
KAISER MEMBERS

This entire section only applies to Direct Payment Plan Participants.

1. Hospital, medical or Drugs that are not Medically Necessary for the care and treatment of a bodily injury, illness or pregnancy.
2. Covered Expenses that are in excess of the Maximum Plan Allowance (MPA) or the Allowed Charge – refer to page 54.
3. Any accidental bodily injury arising out of, or in the course of, the Eligible Individual's employment **or** in connection with an illness for which the Eligible Individual is entitled to indemnity under the provisions of any Workers' Compensation or similar law.
4. Confinements in or treatment by a Veterans Administration (VA) Hospital, **or** for care or treatment obtained from any federal, state or local governmental agency or program where the care or treatment is available without cost to the Eligible Individual, except to the extent the law requires benefits to be paid by the Fund.
5. Confinement or care obtained in a Hospital owned or operated by any federal, state or local governmental agency or program, unless there is an unconditional requirement that the Eligible Individual pay for the confinement or care, without regard to any rights against others, contractual or otherwise.
6. Conditions caused by or arising out of an act of war, armed invasion or aggression.
7. A condition for which the Eligible Individual is not under the care of a Physician, or for a period of confinement beyond that authorized by the Professional Review Organization (PRO).
8. Eye refractions or eyeglasses (may be covered under a separate vision plan).
9. Callus or corn paring; toenail trimming; treatment of chronic conditions of the foot such as weak or fallen arches, flat or pronated foot metatarsalgia, or foot strain.
10. Expenses rendered or provided outside of the United States, its Territories, and Possessions, except for treatment for a life-threatening emergency which, without immediate intervention, would result in placing the Eligible Individual's health in serious jeopardy or serious impairment to bodily functions or serious dysfunction of any bodily part. Some examples of life threatening conditions requiring emergency care include, but are not limited to, heart attacks, strokes, poisoning and appendicitis.

11. Obesity or weight control, except as outlined on page 53.
12. Infertility services as defined by the American College of Obstetrics and Gynecology, including, but not limited to, in vitro fertilization, artificial insemination, surgery, including treatment to alleviate pelvic adhesions (unless determined to be Medically Necessary) and other infertility related services, including charges to reverse voluntary or surgically induced infertility.
13. Experimental or Investigative Procedures except as outlined in Article I., Section 21.00 of the Plan Rules and Regulations.
14. Intentionally self-inflicted injury, or injury or illness resulting from participating in, or in consequence of having participated in, the commission or attempted commission of an assault or felony, unless the injury or illness is the result of domestic violence or is the direct result of an underlying health factor.
15. Cosmetic surgery, including procedures intended to reduce breast size **except for** surgery which is not primarily for beautification but is performed in connection with the Women's Health and Cancer Rights Act - refer to page 62.
16. Pregnancy of an Eligible Individual functioning as a surrogate, or any person functioning as a surrogate to an Eligible Individual. This includes, but it not limited to, prenatal care, labor/delivery and postnatal services of the surrogate.
17. Pregnancy of a Dependent child.
18. Travel expense except in connection with using a Value-Based Site for routine hip or knee replacement surgery that is 50 or more miles from the Eligible Individual's home – refer to page 46.
19. An institution that is primarily a rest home, home for the aged, a nursing home, a convalescent home or any institution of similar character providing Custodial Care.
20. Ambulance transportation that is primarily for the convenience of the Eligible Individual or ambulance transportation by railroad.
21. Services rendered or provided for which an Eligible Individual is not required to pay or which are obtained without cost or for which there would be no charge if the Eligible Individual receiving the treatment were not covered by the Fund.
22. Dental appliances, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, **except** as outlined on page 51.

Death Benefits



Death Benefits for Participants

Whether you are enrolled in the Direct Payment or Kaiser Permanente Plan, you are entitled to Death and Accidental Death and Dismemberment Benefits.

Regular Death

If you die while eligible as a Participant or within 31 days from the loss of your eligibility as a Participant, your designated beneficiary will receive a benefit in the amount of **\$15,000**. Your beneficiary or authorized representative must notify the Trust Fund Office of your death and the beneficiary must provide a copy of the death certificate and complete an Employee Proof of Death form.

Accidental Death

If while eligible as a Participant, you sustain bodily injuries solely through external, violent and accidental means and your death occurs within one year from the date of the accident **as a result of those injuries**, your designated beneficiary will receive a benefit in the amount of **\$15,000** in addition to the Regular Death Benefit for a total benefit in the amount of \$30,000.

Dismemberment

A benefit in the amount of \$7,500 will be payable to you if, while eligible as a Participant, you sustain injuries through external, violent and accidental means and **as a result of those injuries** you suffer the:

- (1) loss of a hand by severance at or above the wrist, or
- (2) loss of a foot by severance at or above the ankle, or
- (3) irrecoverable loss of sight of an eye,

A benefit in the amount of \$15,000 will be payable to you if you suffer more than one of the listed items above.

Limitations for the Accidental Death and Dismemberment Benefits

No more than \$15,000 is payable for any one accident under the Accidental Death and Dismemberment Benefits.

Exclusions for the Accidental Death and Dismemberment Benefits

No Accidental Death or Dismemberment Benefit will be payable if the loss is from:

- Disease, bodily or mental infirmity, medical or surgical treatment, ptomaine or bacterial infection.
- Suicide, attempted suicide or any self-inflicted injury or condition.
- War, acts of war or service of any kind in any armed force of any country.
- Participation in or engagement in any felonious acts.
- Intake of any drug, medication or sedative.
- Intake of alcohol in combination with any drug, medication or sedative.
- Use of alcohol, non-prescription drugs or controlled substances, such as PCP, LSD or any hallucinogens, cocaine, heroin or any other type of narcotic, amphetamines or other stimulant, barbiturates or other sedative or tranquilizer or any combination of any of these substances.

Extended Death Benefits for Former Participants

TOTAL DISABILITY BEGINNING SEPTEMBER 1, 2015

The benefit is no longer available to new totally disabled Participants with a disability onset date of September 1, 2015 or later.

If you are a former Participant who was **1)** under the age of 60 **and 2)** totally disabled on the date your eligibility as a Participant terminated, you may be entitled to extend the Regular Death Benefit until the earlier of age 65 or the date you are no longer totally disabled. If you think you may be qualified for this benefit, contact the Trust Fund Office for the necessary form. You must submit proof of total disability within one year from the loss of your eligibility as a Participant and then annually until your 65th birthday, at which time the Death Benefit ends.

Death Benefit for Dependents

You are entitled to a Dependent Death Benefit in the amount shown below upon the death of your Dependent:

Spouse:	\$7,500
Your Child up to age 26:	\$1,000

DOMESTIC PARTNER

The Plan does not provide any death benefit for the death of your Domestic Partner or his children.

Naming Your Beneficiary

You are free to name any person(s) as your beneficiary on a form approved by the Board. Generally, you will designate your beneficiary on the Enrollment Form. If you would like to designate more than one beneficiary, there is a box on the Enrollment Form for that purpose. Simply check the box and the applicable form will be mailed to you by the Trust Fund Office.

**BENEFICIARY
DESIGNATION**

It is important that you keep your beneficiary designation up-to-date especially if you have named a spouse and you later divorce.

You are free to change your beneficiary at any time. If you do not designate a beneficiary or your designated beneficiary is no longer living at the time of your death, any death benefits due, including, when applicable, the Accidental Death Benefit, will be paid to your spouse. If you have no spouse, benefits will be paid to your surviving relatives in the following order: your child(ren), if none, your mother and father, if none, your brothers and sisters. If none of those family members survive you, the benefit will be paid to your estate.

The Plan will only pay benefits to the beneficiary listed on the Board approved form on file at the Trust Fund Office prior to the date of death.

Overview of Death Benefits


Event	Benefit Amount	Payable To
Your Death (non-accident)	\$15,000	Your beneficiary
Your Death (accidental)	\$30,000	Your beneficiary
Your Dismemberment	\$7,500 - \$15,000 (depending on body parts)	You
Your Death As Totally Disabled (former Participants only)	Up to \$15,000 (depending on date of total disability)	Your beneficiary
Your Spouse Death	\$7,500	You
Your Child (younger than age 26)	\$1,000	You

Employee Assistance Program

Introduction

Personal concerns can have a major impact on your work performance and overall functioning. Claremont Behavioral Services, a firm of select professionals, administers the Trust Fund's Employee Assistance Program (EAP). This Program helps individuals solve personal issues before they become more serious and difficult to manage. You and your Dependents can receive professional and confidential counseling at no cost from this Program. The Program also provides access to resources that can help you address a variety of personal concerns or questions.

CONTACT INFO

 1-800-834-3773

 www.claremonteap.com

Discuss your issue with an experienced counselor who will help you develop an action plan and refer you to resources that are the most appropriate for your needs.

When you need counseling services, you will be referred to a conveniently located counselor or resource with expertise in your area of concern. Day and evening appointments are available as Claremont recognizes your need for prompt and helpful assistance. The EAP is a confidential service. Claremont understands the importance of maintaining your privacy and everything you tell them will be kept confidential. Your involvement with Claremont is afforded the maximum confidentiality permitted under the law.

Covered Services

The following services are covered under your EAP benefits:

- Work/Life consultant's services for referrals and information about:
Child/Elder/Pet Care, Adoption/College/School/Health and Wellness Assistance
- 30 minutes of free consultation, per incident, by an attorney for legal issues such as:
Child Custody, Divorce, Domestic Violence, Personal Injury, Real Estate, Simple Will Kits
- Telephonic consultations on important financial issues such as:
Budgeting, Debt Management, Financial Planning, Identity Fraud Services, Tax Questions

The Program also offers three (3) free counseling visits with an EAP participating provider. This is available to all Participants for any personal issue, including: marital or family conflicts, parenting concerns, substance abuse, anxiety, depression and other issues that affect your quality of life. A web-based video conference with a counselor is available as an alternate to in-person counseling. All you need is a personal computer or tablet to schedule an appointment. Call Claremont for more information regarding video conferencing.

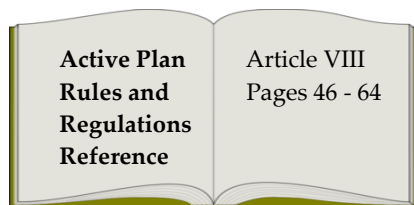
If you are enrolled in the Direct Payment Plan and have used the three free visits, you can continue to see your EAP counselor on a self-pay basis at a discounted rate. You may also begin using your outpatient mental health care or substance abuse treatment benefits but this may require that you find

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After you have exhausted the three free counseling visits through Claremont, you should arrange through Kaiser for any follow-up visits.

another counselor or provider in the Preferred Provider Plan network. If you need inpatient Hospital services for mental health or substance abuse treatment, benefits are payable under the Comprehensive Hospital-Medical Benefits – refer to page 52.

Claims and Appeals Procedures



Claims

This section describes the proper procedures to follow when filing a Claim for benefits and what to do if your Claim is denied.

What is a Claim

A Claim is a request for Plan benefits made according to the Plan's reasonable Claims procedures described in this section. A Claim can be a **"Pre-Service", "Urgent Care", "Concurrent" or "Post-Service Claim"**.

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This entire section only applies to Direct Payment Plan Participants.

What is not a Claim

- Simple or general inquiries about the Plan's provisions that are unrelated to any specific benefit Claim.
- Request for a determination regarding the Plan's coverage of a medical treatment or service that your Physician has recommended, but that treatment or service has not yet been provided and the treatment or service is for non-urgent care that does not require prior authorization from the Plan. In this case, you may request a determination from the Trust Fund Office regarding the Plan's coverage of the treatment or service. However, any determination from the Trust Fund Office is not a guarantee of payment because the request is not a Claim and, therefore, is not subject to the requirements and timelines of a "Claim."
- Request for a prescription to be filled under the terms of the Plan is not a Claim under these procedures. If, however, your request for a prescription to be filled is denied, you are entitled to file a Claim and appeal the denial by using the procedures described in this section.

What is an Adverse Benefit Determination

This is a denial, reduction or termination of a Claim or for the failure to pay for all or part of a Claim for benefits. Some examples of an Adverse Benefit Determination include, but are not limited to, the following:

- Payment of less than 100% of the benefit owed under the terms of the Plan;
- Denial or reduction in a benefit as a result of a Utilization Review or Pre-Authorization Review decision, network exclusion, or other Plan limitation;
- Failure to provide a benefit because the service or item is considered Experimental or Investigative, not Medically Necessary or not medically appropriate;

- Denial because the claimant is not considered eligible under the Plan; **or**
- The Rescission of coverage for benefits.

A Participating Provider (Physician, Hospital or other covered health care provider) or pharmacy that fails to provide a service or fill a prescription unless the Eligible Individual pays the entire cost is **NOT** an **Adverse Benefit Determination** if that refusal is based on the Plan's Rules and Regulations.

What is an Independent Review Organization (IRO)

This is an entity that will conduct an independent External Review of an Adverse Benefit Determination. The IRO will be required to follow the Plan's External Review procedures as well as any applicable federal regulations.

What is a Rescission of Coverage

A Rescission means the retroactive cancellation or termination of coverage for reasons other than fraud, misrepresentation or non-payment of premiums.

Claims Procedures

In most cases, your health care provider will submit a Claim on your behalf. If you require a Claim Form, you may obtain one from the Trust Fund Office or your health care provider can use a "universal claim form".

What must be included on a Claim?

To be considered a "Claim", your request for benefits must include the following information:

- Participant's full name;
- Patient's full name;
- Patient's date of birth;
- Participant's Health Plan ID number or Social Security Number;
- Date of Service;
- CPT code (the code for Physician services and other health care services found in the "Current Procedural Terminology, as maintained and distributed by the American Medical Association);
- ICD code (the diagnosis code found in the International Classification of Diseases Clinical Modification as maintained and distributed by the US Department of Health and Human Services (HHS));
- Billed charge (bills must be itemized, showing all dates of services);
- Number of units (for example, anesthesia and certain other services);
- Federal Taxpayer Identification Number (TIN) of the provider;
- Provider's billing name, address, phone number and professional degree or license;
- Details of the accident if treatment is due to an injury; **and**
- Information of other insurance coverage, if any.

Types of Claims

Pre-Service Claims

A Pre-Service Claim is a Claim for benefits that requires approval by the Plan **before** medical care is obtained. Pre-approval will allow you to receive the maximum benefits available under the Plan. For example, if you are to be confined in a Hospital for an elective surgery, you or your Physician must arrange Utilization Review (UR); otherwise, you may be responsible for more out-of-pocket expenses.

When to File a Pre-Service Claim

Circumstances under which you should submit a Pre-Service Claim are listed below.

Pre-Service Claims for all:

- Elective, non-emergency Hospital admissions
- Surgical treatment for morbid obesity
- Hospice Care
- Home Health Care

CONTACT INFO
Anthem Blue Cross
 1-800-274-7767

For a properly filed Pre-Service Claim, you and your health care provider will be notified of a decision within **15 days** from receipt of the Claim, unless additional time is needed to make a decision. If necessary, an extension of up to **15 days** may be required due to matters beyond the control of the Plan. You will be notified of the circumstances requiring an extension of time and the date a decision will be made available to you.

If an extension is necessary because additional information is required, the request will specify the information needed. In this case, you or your health care provider will have **45 days** from receipt of the notification to submit the additional information. If that information is not provided within **45 days**, your Claim will be denied. During the period in which you are allowed to provide additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until **45 days** have elapsed or the date you respond to the request, whichever occurs sooner. Once your response is received, the Plan has **15 days** to make a decision on a Pre-Service Claim.

If your health care provider does not file a Pre-Service Claim properly, you and your health care provider will be notified as soon as possible, but not later than **5 days** after receipt of the Claim. This notice will advise you of the proper procedures for filing the Claim. You and your health care provider will only receive notice of an improperly filed Pre-Service Claim if the Claim includes **1)** your name, **2)** your specific medical condition or symptom, and **3)** a specific treatment, service or product for which approval is requested. Unless the Claim is resubmitted properly, it will not constitute a “Claim” and will not be acted on.

Urgent Care Claims

CONTACT INFO

Anthem Blue Cross



1-800-274-7767

**Do not submit by
US Postal Service.**

An Urgent Care Claim is any Claim for medical care or treatment that, if handled within the time frames of a Pre-Service Claim as described above, could seriously jeopardize the life or health of the individual or his ability to regain maximum function or, in the opinion of the Physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot adequately be managed without the care or treatment in the Claim.

Your Urgent Care Claim is reviewed by Anthem Blue Cross and a determination will be made by applying the judgment of a prudent layperson possessing an average knowledge of health and medical Claims processing. Any Claim made by a health care provider, who has knowledge of your medical condition and determines that it is an Urgent Care Claim will be treated as an Urgent Care Claim.

If you are requesting approval of an Urgent Care Claim, the response time differs, depending on whether your request contains sufficient information for making a determination. If the request contains sufficient information, Anthem Blue Cross will respond to you and your health care provider with a determination, by telephone, as soon as possible, taking into account the medical urgency of the patient's condition, but not later than **72 hours** after receipt of the Claim by Anthem Blue Cross. The decision will be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or not benefits are covered or payable or to what extent benefits are covered or payable, Anthem Blue Cross will notify you and your health care provider as soon as possible, but not later than **24 hours** after receipt of the Claim, of the specific information necessary to complete the Claim. You or your health care provider must provide the specified information within **48 hours**. Notice of the decision will be provided no later than **48 hours** after the Plan receives the specified information, but only if the information is received within the required time frame. If the information is not provided within the time frame, your Claim will be denied.

Concurrent Claims

A Concurrent Claim is a Claim that is reconsidered after an initial approval was made and, after reconsideration, results in a reduction, termination or extension of a benefit. An example of a Concurrent Claim is an inpatient Hospital stay that was originally authorized for 5 days and is reviewed after 3 days to determine if the full 5 days is still appropriate. In this example, a decision to reduce, terminate or extend the inpatient Hospital stay is made concurrently with the provision of medical treatment. Reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of an approved benefit will be made by the Trust Fund Office or Anthem Blue Cross as soon as possible but, in any event, in time to allow you to appeal the decision before the benefit is reduced or terminated.

Any request by a claimant to extend approved urgent care treatment will be acted upon by Anthem Blue Cross within **24 hours** of receipt of the Claim, provided the Claim is received at least **24 hours** prior to the expiration of the approved treatment. A request to **extend** approved treatment that does

not involve urgent care will be decided upon according to Pre-Service or Post-Service time frames, whichever apply.


Post-Service Claims

Claims that are not Pre-Service, Urgent Care or Concurrent are considered Post-Service Claims. An example of a Post-Service Claim is any Claim submitted for payment after medical services or treatment has been obtained.

Usually, you will be notified of the decision on your Post-Service Claim within **30 days** from the date the Plan receives your Claim. This period may be extended one time by the Plan for up to **15 days** if an extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial **30-day** period of the circumstances requiring the extension of time and the date by which the Plan expects to make its decision.

Where to File a Post-Service Claim

Post-Service Claims are considered “**filed**” as soon as they are electronically filed with Fund’s designee, Anthem Blue Cross, or the “host plan” under the **BlueCard PPO** national network.

 **Claims not submitted electronically, MAIL to:**
Anthem Blue Cross
PO Box 60007
Los Angeles, CA 90060

When to File a Post-Service Claim

Post-Service Claims should be filed as soon as reasonably possible but in no event more than one year from the date of service.

Notice of Initial Benefit Determination

When you submit a Claim, you will be provided with **written** Notice of an Initial Benefit Determination (decision). If the decision is an “Adverse Benefit Determination”, your notice must include:

- The identity of the Claim involved, including the date of service, the provider and the Claim amount;
- Information concerning the diagnosis code, treatment code and what those codes mean which is available upon request and without charge;
- The specific reason for the Adverse Benefit Determination, including the denial code and what the code means and the standards the Plan used in making the Adverse Benefit Determination;
- The specific Plan provision on which the Adverse Benefit Determination is based;
- A description of any additional material or information necessary to complete your Claim for benefits and why that material or information is necessary;

- A description of the Plan's Internal Appeal procedure and External Review process, including the time limits and how to begin the appeal process;
- A statement of your right to bring civil action under ERISA §502(a) after receiving an Adverse Benefit Determination;
- Information on any internal rule, guideline or protocol used in making an Adverse Benefit Determination on your Claim and that you are entitled to a copy of that material without charge;
- Any information, explanation or documentation used if the Adverse Benefit Determination is based on the absence of medical necessity or the treatment was considered Experimental or Investigative or not medically appropriate, and will be furnished without charge;
- The availability and contact information for the assistance of an ombudsman to assist with the Internal Appeal and External Review processes; **and**
- With respect to Urgent Care Claims, a description of the expedited review process available for these types of Claims.

How to Appeal an Adverse Benefit Determination through the Internal Appeals Procedures

If your Claim is denied in whole or in part, (an Adverse Benefit Determination) or if you disagree with the decision made on your Claim, you **or your Authorized Representative** may request a review by the Board through the Internal Appeals process. Your request for review must:

- Be made in writing;
- State the reason(s) for disputing the denial (the Adverse Benefit Determination);
- Include any pertinent materials not already furnished to the Plan; **and**
- Be submitted within 180 days from the date you receive the Adverse Benefit Determination.

Authorized Representative

A claimant may designate a person to act as his authorized representative, such as a spouse or an adult child, to submit a request for review on behalf of the claimant. The claimant must sign and submit a written authorization form that has been approved by the Board. The Trust Fund Office may request additional information to verify that the designated person is authorized to act on the claimant's behalf.

A health care provider with knowledge of the claimant's medical condition may act as an Authorized Representative in connection with a request for a review of an Adverse Benefit Determination without the claimant having to designate the health care provider to act.

The Internal Appeals Procedures

You have the right to review documents relative to your Claim. A document, record or other information is “relevant” if it was relied upon by the Plan in making the decision on your Claim; it was submitted, considered, or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan’s administrative processes for providing consistent decision making; or it constitutes a statement of Plan policy regarding the denied treatment of service.

Upon request, you will be provided with the identification of the appropriate medical expert, consultant, or advisor, if any, that gave advice to the Plan on your Claim, without regard to whether the advice of those experts was relied upon in deciding your Claim.

Your Claim will be reviewed by someone other than the person who made the original decision. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including any additional documents and comments that may be submitted by you.

If your Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigative or experimental), a health care professional with the appropriate training and experience in a relevant field of medicine will be consulted.

When You Can Expect a Decision through the Internal Appeals Process

Pre-Service Claims: You can expect to receive a decision within **30 days** from receipt by the Trust Fund Office of your request for a review of your denied Claim.

Urgent Care Claims: You can expect to receive a decision within **72 hours** of receipt by the Trust Fund Office of your request for a review of your denied Claim.

Post-Service Claims: Usually, decisions involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt by the Trust Fund Office of your request for review. However, if your request for review is received by the Trust Fund Office within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request for review. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised, in writing, in advance if this extension will be necessary. Once the decision on your Claim has been reached, you will be notified as soon as possible, but no later than **5 days** after the decision has been made.

Content of the Appeal Decision Notice

The decision on your appeal will be provided to you in writing.

If the decision is an Adverse Benefit Determination, the notice will include:

- The identity of the Claim that was denied, including the date of service, the provider and the Claim amount;
- Information concerning the diagnosis code, treatment code and what those codes mean which is available upon written request and without charge;
- The specific reason for the Adverse Benefit Determination, including the denial code and the meaning of that code as well as the standards of the Plan used in making the determination;
- The specific Plan provision on which the Adverse Benefit Determination is based;
- A statement advising that you are entitled to reasonable access to and copies of all documents that apply to your Claim, upon written request and without charge;
- A statement of your right to bring civil action under ERISA §502(a) after an appeal of an Adverse Benefit Determination;
- An explanation of any External Review process, including any time limits and information on how to start the next level of review;
- A copy of any internal rule, guideline or protocol used in the determination of your appeal, upon written request and without charge;
- Information, explanation or documentation if the determination is based on medical necessity, the treatment was Experimental or Investigative or not medically appropriate. This information will be available upon written request and without charge; **and**
- A statement that you and your Plan may have other voluntary dispute resolution options such as mediation as well as disclosure of the availability and contact information of an ombudsman to assist you with the Internal and External Review processes. Information concerning these options are available from the U.S. Department of Labor.

External Review Process

If you are still not satisfied with the decision made after participating in the Plan's Internal Appeals process, you have the right to seek an External Review. An Independent Review Organization (IRO) will perform this review. This review is available for health care Claims whether they are Pre-Service, Urgent, Concurrent or Post-Service Claims **and** fit within the following parameters:

1. The denial involves a medical judgment, including, but not limited to, those based on the Plan's rules concerning medical necessity, medical appropriateness, health care setting, level of care or a determination that the treatment is Experimental or Investigative. The IRO will determine if the denial involves a medical judgment; and/or

2. The denial is due to a Rescission of Coverage.

The External Review process does not apply to any other types of Adverse Benefit Determinations and only applies to health care Claims. In most cases, you can only request an External Review after you have exhausted the Plan's Internal Appeals process. This means you must have received a final determination on an internal review before you can request an External Review.

Because the External Review process is only available for Claims involving medical judgment, there are only two types of Claims that will be considered. They are: 1) Standard (Non-Urgent) Claims; and (2) Expedited Urgent Claims.

External Review of Standard (Non-Urgent) Claims

You must request an External Review in writing and within 4 months after receiving an Adverse Benefit Determination through the Internal Appeals process.

A. Preliminary Review of Standard Claims.

1. The Plan has **5 business days** to complete a preliminary review of your request for an External Review. The preliminary review will determine whether:
 - (a) You were covered under the Plan at the time of the health care service or item was requested.
 - (b) The Adverse Benefit Determination does not involve eligibility requirements, including the failure to pay required premiums;
 - (c) You have exhausted the Plan's Internal Appeals process; and
 - (d) You have provided all of the requested information and forms to complete the External Review.
2. Within **1 business day** after completing the preliminary review, the Plan will notify you if you have met all of the requirements for an External Review. The notification will inform you:
 - (a) If your request is complete and eligible for an External Review; **or**
 - (b) If your request is complete, but not eligible for an External Review and why it is not eligible for an External Review. The notification will also provide you with the contact information of the Employee Benefits Security Administration (EBSA).
 - (c) If your request is incomplete, the notification will describe the information or material needed to complete your request for an External Review. You must perfect your request within the 4 month filing period or within 48 hours following receipt of the notification, whichever is later.

B. Review of Standard Claims by an Independent Review Organization (IRO).

1. If your request is complete and eligible for an External Review, the Plan will assign your request to an IRO. Once the Claim is assigned to an IRO, the following procedure will apply:
 - (a) The IRO will notify you in writing that it has received your request confirming your eligibility for an External Review and the IRO's acceptance of the request. You will also be given directions on how to submit additional information which should be submitted within **10 business days**.
 - (b) Within 5 business days of assigning your request for External Review to the IRO, the Plan will furnish the IRO with documents and information the Plan used in making the Adverse Benefit Determination.
 - (c) If you submit additional information to the IRO, the IRO must forward that information to the Plan within **1 business day** so that the Plan may use that information in reconsidering the initial Adverse Benefit Determination. In no event will this reconsideration by the Plan delay the External Review. If the Plan reverses the Adverse Benefit Determination, the Plan must notify the IRO within **1 business day** and the External Review process will terminate.
 - (d) The IRO will review all of the information and documents that have been received in a timely manner. The IRO is not bound by any decision made by the Plan; however, the IRO will be bound by the terms of the Plan and cannot override the Plan Rules. As part of the External Review, the IRO may consider your medical records, recommendations from your treating health care provider, appropriate practice guidelines and other related medical information.
 - (e) The IRO will provide you and the Plan with a written notice of its final External Review decision within **45 days** after receiving the request for External Review.
 - (f) The IRO's decision notice will include:
 1. Information sufficient to identify the Claim, diagnosis code, treatment code, the meaning of these codes and the reason for the previous denial;
 2. The date the IRO received the request for External Review and the date of the decision;
 3. The evidence or documentation considered in reaching the decision, including specific Plan provisions and evidence based standards;
 4. A discussion of the reasons for the IRO's decision;

5. A statement that the Plan must comply with the IRO's decision;
6. A statement that a review by a court may be available, including the contact information for the Office of Health Care Consumer Assistance or ombudsman to assist you with your External Review.
7. If the IRO decision reverses the Plan's Adverse Benefit Determination, upon receipt of this notice by the Plan, the Plan must immediately comply with the IRO's decision. However, the Plan still has the right to seek review by a court to change the IRO's decision; **or**
8. If the IRO upholds the Plan's Adverse Benefit Determination, you may seek review of the result of the External Review under ERISA §502(a).

External Review of Expedited Urgent Care Claims

A. You may request an Expedited External Review if:

1. You receive an adverse **initial** Claim Benefit Determination that involves a medical condition which requires a quicker response so as to not jeopardize your life or health, and you have filed a request for an expedited internal review; or
2. You receive an Adverse Benefit Determination on an Internal Appeal that involves a medical condition which requires a quicker response so as to not jeopardize your life or health; or you receive an Adverse Benefit Determination that concerns an admission or availability of care for which you received emergency services but have not been discharged from the facility.

B. Preliminary Review for an Expedited Claim.

The Plan will immediately take the following steps:

1. Upon receipt of the request for an External Review, the Plan will complete a Preliminary Review;
2. After completing the Preliminary Review, the Plan will notify you by telephone as to whether or not your request met the Preliminary Review criteria; **and**
3. If the request does not meet the Preliminary Review criteria, you will be advised of what information is still needed.

C. Review of Expedited Claim by an Independent Review Organization (IRO).

The procedure for an External Review of an Expedited Claim by an IRO is the same as that of the IRO's review for Standard (Non-Urgent) Claims with one exception. An External Review for an Expedited Claim must be resolved within **72 hours or less**.

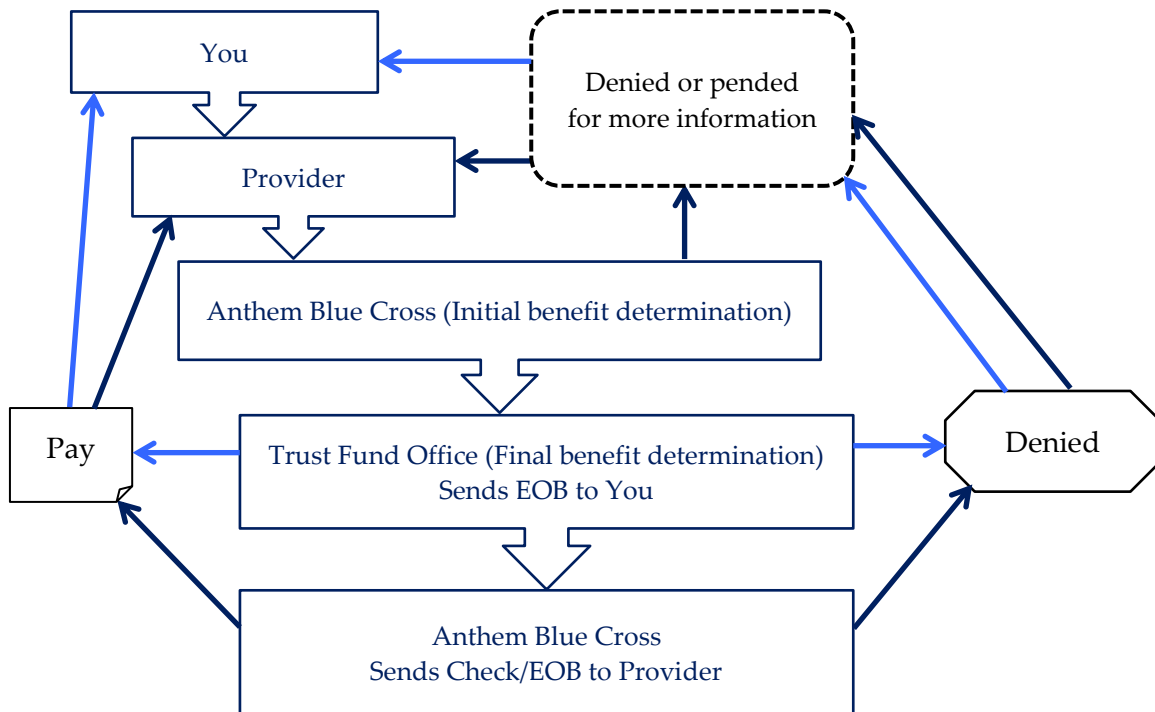
Once you receive the decision of the IRO regarding the External Review of your Expedited (Urgent) Claim, you have a right to seek review by a court under ERISA §502(a).

Limit on When You May Begin a Lawsuit (Civil Action)

You may not begin a lawsuit against the Fund to obtain benefits until after the following events have occurred, regardless of the type of Claim submitted:

- You requested an internal review of the denial of your Claim and the Board has reached and issued a final decision on your review; **or**
- You requested an External Review, but have not received either a notice within the specified time frames that a **final** decision has been reached **or** a notice that an extension will be necessary to reach a **final** decision.

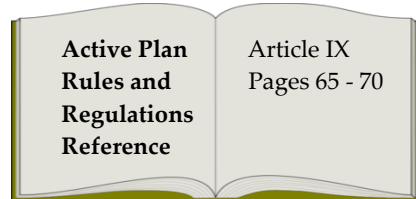
Claims Processing Flow Chart



Overview Chart for External Review Process

Step	Steps in the External Review Process	Time Frame for Standard (non-urgent) Claims	Time Frame for Expedited Urgent Care Claims
1	Claimant requests an External Review (generally after the Internal Claims Appeals procedures have been exhausted)	Within 4 months after receipt of an Adverse Benefit Determination (benefits denial notice)	After receipt of an Adverse Benefit Determination (benefits denial notice)
2	The Plan performs a preliminary review	Within 5 business days following the Plan's receipt of the request for an External Review	Immediately
	Plan sends notice to claimant regarding the results of the preliminary review	Within 1 business day after the Plan's completion of the preliminary review	Immediately
	When appropriate, claimant's time frame for perfecting an incomplete External Review request	The remainder of the 4 month filing period, or if later, 48 hours following receipt of the notice that the External review is incomplete	Immediately
3	Plan assigns case to the Independent Review Organization (IRO)	In a timely manner	Expediently
4	Notice from the IRO to the claimant advising that the case has been accepted by the IRO for External Review along with the time frames for submission of any additional information	In a timely manner	Expediently
5	Time period for the Plan to provide the IRO documents and information that the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expediently
6	Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information (the IRO may accept information after 10 business days)	Expediently
7	The IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expediently
8	If, on account of the new information submitted by the claimant, the Plan reverses its denial and provides coverage, a Notice is provided to the claimant and the IRO	Within 1 business day of the Plan's decision	Expediently
9	The External Review decision by the IRO to the claimant	Within 45 calendar days of the IRO's receipt of the request for an External Review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for an expedited External Review (if notice is not in writing within 48 hours of the date of providing such non-written notice, the IRO must provide written notice to the claimant and the Plan)
10	Upon Notice from the IRO that it has reversed the Plan's Adverse Benefit Determination	Plan must immediately provide coverage or payment for the Claim	Plan must immediately provide coverage or payment of the Claim

Information Required Under Health Insurance Portability and Accountability Act (HIPAA)



Privacy of Your Health Information under HIPAA

This section describes how Health Information about you or your Dependents may be used and disclosed and how you or your Dependents can obtain access to Health Information maintained by the Laborers Health and Welfare Trust Fund for Northern California (“Health Plan”).

You have certain rights under the HIPAA Privacy Rule with regard to your Health Information maintained by the Laborers’ “Health Plan”.

The HIPAA Privacy Rule establishes national standards to protect individuals’ medical records and other personal Health Information and applies to Health Plans, health care clearinghouses, and those health care providers that conduct certain electronic health care transactions. This Privacy Rule requires appropriate safeguards be put in place to protect the privacy of personal Health Information and sets limits and conditions on the uses and disclosures of that information without patient authorization. The Privacy Rule also gives patients certain rights regarding their Health Information, including the right to examine and obtain a copy of health records and to request corrections.

Privacy Notice

The HIPAA Privacy Rule requires Health Plans, as well as covered health care providers, develop and distribute a “notice” that provides a clear, user friendly explanation of individual’s rights with respect to their personal Health Information and the privacy practices of Health Plans and health care providers. In the case of the Health Plan, you will be provided with a Privacy Notice which will be included in the New Eligible Packet you receive from the Trust Fund Office once your eligibility under the Plan has been established. While you remain eligible under the Plan, you can expect to receive a Privacy Notice every three years. You can also read or download a copy of the Privacy Notice on the Trust Funds’ website.

The Privacy Notice explains how the Laborers’ Health Plan, which is a member of an “Organized Health Care Arrangement”, uses and discloses your Health Information, and what rights you have with respect to that information. The terms “Plan”, “Plan Administration Team” and “Team Member” apply to the Health Plan in which you are a Participant.

Contact the Fund’s HIPAA Compliance Director at ☎ 1-800-244-4530 or 1-707-864-2800 if you have questions about the Privacy Notice.

You can also learn more about HIPAA and your Privacy Rights by visiting the website for the Department of Health and Human Services/Health Information Privacy: 🌐 www.hhs.gov/ocr/privacy

Changes to the Privacy Notice

The Laborers' Health Plan reserves the right to change the content of the Privacy Notice but the Privacy Notice must always comply with the requirements of HIPAA.

Other Privacy Notices

Your health care providers are also required by HIPAA to provide you with a Privacy Notice. Those privacy notices differ from the Laborers' Health Plan notice because they discuss how your health care providers use your Health Information. The Laborers' Health Plan Privacy Notice applies only to the Protected Health Information (PHI) obtained and maintained by the Health Plan and describes your rights with respect to your Health Information maintained **by the Health Plan**, and how the Health Plan may use and disclose that Health Information.

Who Sees Your Health Information

The Plan Administration Team includes all individuals who must see Health Information that can be linked to an individual's Protected Health Information (PHI) in order to operate the Health Plan. Members of the Team are employees of the Fund's Administrative Office which handles the day-to-day operation of the Health Plan.

Other members of the Team include employees of outside organizations that assist with the operation of the Health Plan. In order to serve as Team Members, an individual must complete extensive training on privacy and security procedures. The law prohibits Team Members from using Protected Health Information (PHI) for improper purposes. Each Team Member understands that a violation of the Health Plan's privacy and security procedures may result in disciplinary action. Therefore, Team Members take the privacy of your Health Information seriously.

The Health Plan's Promise to You

Plan Administrative Team Members understand that your Health Information is private. The Board of Trustees for the Laborers Health and Welfare Trust Fund for Northern California is committed to using your Health Information only for the purposes of treatment, paying benefits, operating the Health Plan and, as expressly permitted or required by law.

How the Health Plan Uses and Discloses Your Health Information

Team Members can only use and disclose Protected Health Information (PHI) in ways that are expressly permitted by HIPAA. The sections entitled "Treatment", "Payment", and "Health Care Operations" describe how the Health Plan uses and discloses the Health Information obtained about you (your "Health Information"). Some of these uses and disclosures are routine, and are necessary to operate the Health Plan, and to provide assistance to health care providers who treat you. Others are not routine, but are required by law or necessary due to special circumstances. The Health Plan has developed procedures for all of these uses and disclosures. Because the Health Plan is a member of an "Organized Health Care Arrangement", the Health Plan may share your information with other members of the

“Organized Health Care Arrangement” for the purpose of “Treatment”, “Payment”, and “Health Care Operations”.

Treatment. Team Members may use or disclose your Health Information to facilitate medical Treatment or services by your health care providers such as doctors, nurses, technicians, medical students, other hospital personnel or pharmacies.

Payment. Team Members may use and disclose your Health Information in order to determine your eligibility for Health Plan benefits, to process Claims for Payment for your Treatment, or to determine whether any other plan or party might be responsible for Payment of your Treatment. For example, a Team Member might review a bill that contains Health Information about you in order to determine whether the Treatment is a Covered Expense under the Laborers’ Health Plan. Sometimes, a Team Member must obtain information from a health care provider or from your medical record to determine whether the Treatment provided is Medically Necessary, experimental or investigative. One Team Member may send information to another Team Member who is a medical specialist for the purpose of obtaining a medical opinion concerning the nature of the Claim. These are just a few examples of how Team Members may use and disclose your Health Information in order to make sure the benefits are properly paid.

Health Care Operations. Team Members may use and disclose your Health Information in order to conduct Health Plan operations. For example, Team Members may review your Health Information in order to:

1. Conduct quality assessment and improvement activities;
2. Perform underwriting, premium rating, and other activities relating to Health Plan coverage;
3. Submit Claims for stop-loss (or excess loss) coverage;
4. Conduct or arrange for medical review, legal services, audit services, and fraud and abuse detection programs;
5. Learn about ways to manage costs; **and**
6. Manage the business of the Health Plan to make sure it is administered properly and effectively.

Required By Law. Team Members will disclose your Health Information when required to do so by federal, state or local law. For example, a Team Member will disclose information about medical bills submitted by your health care provider in response to a court order in a litigation proceeding that claims the provider is involved in fraudulent bill practices.

To Prevent Serious Threats to Health or Safety. Team Members may use and disclose your Health Information in order to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure of this nature would only be made to a person who is able to help prevent the threat.

Special Situations

Organ and Tissue Donation. If you are an organ donor, Team Members may release your Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, in order to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces of the United States or any other country, Team Members may release your Health Information if the Health Plan is required to do so by the appropriate military command authorities.

Workers' Compensation. Team Members may release your Health Information if required to in order to comply with Workers' Compensation laws.

Health Oversight Activities. Team Members may disclose your Health Information to a Health Oversight Agency for activities authorized by law. These oversight activities may include audits, investigations, inspections and licensure. The activities are necessary for the government to monitor the health care system, government programs and compliance of civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, Team Members may disclose your Health Information in response to a court or administrative order. Team Members may also disclose your Health Information in response to a subpoena, discovery request, or other legal process by someone involved in the dispute, but only if efforts have been made to inform you of the request.

Law Enforcement. If requested to do so by a Law Enforcement Official, a Team Member may release your Health Information in response to a court order, subpoena, warrant, summons, or similar process.

Coroners, Medical Examiners and Funeral Directors. Team Members may release your Health Information to a coroner or medical examiner. This may be necessary, for example, to identify you if you die or to determine the cause of your death. Team Members may also release your Health Information to funeral directors as necessary to carry out their duties.

Your Rights Regarding Health Information the Plan Maintains About You

You have the following rights regarding the Health Information the Health Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy your Health Information used to make decisions about your Health Plan benefits. To inspect and copy the medical information used to make these decisions, you must complete a form entitled **"Request for Access to Protected Health Information (PHI)"** and submit this form to the Fund's HIPAA Compliance Director. If you request a copy of the information, you may be charged for the cost of copying, mailing and for any supplies associated with your request.

Right to Amend. If you believe the Health Plan has medical information about you that is incorrect or incomplete, you may ask that your Health Information be amended. You have the right to request an amendment for as long as the information is retained by or for the Health Plan. To request an amendment, you must complete a form entitled **"Request for Amendment of Protected Health**

Information (PHI)” and submit this form to the Fund’s HIPAA Compliance Director. Your request for an amendment may be denied if you do not complete this form. In addition, **your request may be denied if you ask the Fund to amend information that:**

1. Is not part of the medical information retained by or for the Health Plan;
2. Was not created by the Health Plan;
3. Is not part of the information which you would be permitted to inspect and copy; **or**
4. Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an “Accounting of Disclosures” where disclosures were made for any purpose other than Treatment, Payment, or Health Care Operations.

To request a list or Accounting of Disclosures, you must complete the form entitled **“Request for an Accounting of Disclosures of Protected Health Information (PHI)”** and submit this form to the Fund’s HIPAA Compliance Director. Your request must state the period of time for which you are requesting an Accounting of Disclosures. This period may not be longer than 6 years. Your request should indicate in what form you want to receive this information (for example: paper or electronic). The first request for information within a 12-month period will be free of charge. If you make any additional requests for information, the Trust Fund Office may charge you for the cost of providing this information. You will be notified of the cost in advance and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the Right to Request Restrictions or limitations on the Health Information the Health Plan uses or discloses about you for Treatment, Payment or Health Care Operations. You also have the right to request a limit on the Health Information **the Health Plan** discloses about you to someone who is involved in your care or the Payment for your care, such as a family member or friend. For example, you could request that the Health Plan not use or disclose Health Information to your spouse in connection with medical procedures.

To request that restrictions be placed on the disclosures of your Health Information, you must complete the form entitled **“Request for Restriction of Protected Health Information (PHI)”** and submit this form to the Fund’s HIPAA Compliance Director. You should understand that the HIPAA Compliance Director is not obligated to comply with your request.

Right to Request Confidential Communications. If you believe that the normal form of communication of Health Information is unacceptable, you have the right to request that the Health Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can request that the Health Plan only contact you at work or by mail.

To request confidential communications, you must complete the form entitled **“Request for Confidential Communications of Protected Health Information (PHI)”** and submit this form to the Fund’s HIPAA Compliance Director. You will not be asked the reason for your request and the

Administrative Office will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Laborers Health and Welfare Trust Fund for Northern California (Health Plan) or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with the Health Plan, write to the Fund's HIPAA Compliance Director.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or any law that applies to the Laborers Health Plan will be made only with your written authorization. If you provide the Health Plan with an authorization to use or disclose Health Information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Health Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You should understand that the Health Plan will be unable to recall any disclosures already made based upon your authorization. To request authorization for use or disclosure of your Protected Health Information (PHI), you must complete the form entitled **"Authorization for Use or Disclosure of Protected Health Information"** and submit this form to the Fund's HIPAA Compliance Director.

Where to Obtain HIPAA PHI Forms

You can call the Trust Fund Office and ask that the form(s) be mailed to you or you may print any of the HIPAA PHI forms from the Trust Funds' website:

- Request for Access to Protected Health Information (PHI)
- Request for Amendment of Protected Health Information (PHI)
- Request for an Accounting of Disclosures of Protected Health Information (PHI)
- Request for Restriction of Protected Health Information (PHI)
- Request for Confidential Communications of Protected Health Information (PHI)
- Authorization for Use or Disclosure of Protected Health Information (PHI)

Where to File Complaints or Send Completed HIPAA PHI Forms

All complaints and completed HIPAA PHI Forms should be submitted to:



Northern California Laborers Funds Administration, Inc.
HIPAA Compliance Director
220 Campus Lane
Fairfield, CA 94534-1498

Organizations through Which Benefits are Administered or Provided

In accordance with disclosure requirements of the Health Insurance Portability and Accountability Act of 1996, listed on the next page are the names and addresses of all health care providers. The Plan is sponsored and administered by the Board of Trustees, however, have delegated administrative responsibilities to these organizations and the Trust Fund Office.

Department of Labor

HIPAA also requires that the Trust Fund Office inform you of the Department of Labor address in Washington, D.C. If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor:



EBSA

U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20201

Contact Information

Organization Name and Address	Telephone and Website Address	Responsibilities
Laborers Health and Welfare Trust Fund for Northern California 220 Campus Lane Fairfield, CA 94534	1-707-864-2800 1-800-244-4530 within California www.norcalaborers.org Send email to: customerservice@norcalaborers.org	Maintains eligibility records; Accounts for employers and self-payment contributions; Administers Direct Payment Plan; Handles routine administrative functions.
Anthem Blue Cross of California 21555 Oxnard Street, M/S 10-H2 Woodland Hills, CA 91367	1-800-274-7767 Utilization Review 1-800-810-2583 BlueCard www.anthem.com/ca www.bluecares.com BlueCard	For Direct Payment Plan Participants: Provides access to provider network services, utilization review for inpatient hospitalization and case management; Issues health plan id cards; Coordinates with BlueCard PPO.
OptumRx 3515 Harbor Boulevard Costa Mesa, CA 92626	1-800-797-9791 Customer Service 1-800-834-3773 Mail Order www.optumrx.com	For Direct Payment Plan Participants: Administers and provides access to contracting pharmacies, mail-service program and specialty drugs.
BriovaRx 8350 Briova Drive Las Vegas, NV 89113	1-855-427-4682 Customer Service www.briovarx.com	For Direct Payment Plan Participants: Administers and provides access to specialty drugs.
Claremont Behavioral Services 1050 Marina Village Parkway, #203 Alameda, CA 94501	1-800-834-3773 www.claremonteap.com	For all Participants: Administers and provides access to Employee Assistance Program (EAP).
Kaiser Foundation Health Plan 1950 Franklin Street Oakland, CA 94612	1-800-464-4000 Customer Service www.kaiserpermanente.org	For Kaiser Permanente Plan Participants: Administers and provides access to Kaiser facilities for hospital-medical, prescription drugs and vision care.
Delta Dental of California 100 First Street San Francisco, CA 94105	1-800-765-6003 Customer Service www.deltadentalins.com	Administers and provides access to dental providers to all Participants enrolled in the Delta Dental Plan.
Private Medical Care, Inc. (PMI) DeltaCare Group Dental Service 12898 Towne Center Drive Cerritos, CA 90703	1-800-422-4234 Customer Service www.deltadentalins.com	Administers and provides access to dental providers to all Participants enrolled in the DeltaCare USA.
Bright Now! Dental Plan 201 E. Sandpointe, Suite 200 Santa Ana, CA 92707	1-888-274-4486 Customer Service www.brightnow.com	Administers and provides access to dental providers to all Participants enrolled in the Bright Now! Dental Plan.
UnitedHealthcare Dental Plan 1390 Willow Pass Road Concord, CA 94520	1-800-999-3367 Customer Service www.myuhcdental.com	Administers and provides access to dental providers to all Participants enrolled in the UnitedHealthcare Dental Plan.
Anthem Blue View Vision PO Box 8504 Mason, OH 45040	1-866-723-0515 Customer Service www.anthem.com/ca	Administers vision care benefits and provides access to providers to all Participants.

Information Required by Employee Retirement Income and Security Act ERISA of 1974

1. The Plan is administered by a Joint Board of Trustees at the following address:

Board of Trustees
Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane
Fairfield, CA 94534-1498
1-800-244-4530 within California
1-707-864-2800 all other locations

2. The Trust Fund Office will provide any Eligible Individual, upon written request, information as to whether a particular employer is contributing to the Fund with respect to the work of Participants in the Fund and if the employer is a contributor, and the employer's address.
3. The Employer Identification Number (EIN) issued to the Board of Trustees by the Internal Revenue Service is 94-1235152.
4. The Plan Number is 501.
5. This is a Welfare Plan that provides hospital, medical, drug, dental, vision care and death and accidental death and dismemberment benefits.
6. The designated person for the service of legal process is the Fund Administrator. Legal process may be served upon:

Fund Administrator
Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane
Fairfield, CA 94534-1498

7. This program is maintained pursuant to various collective bargaining agreements. Copies of the collective bargaining agreements are available for inspection at the Trust Fund Office during regular business hours and, upon written request, will be furnished by mail. A copy of any collective bargaining agreement which provides for contributions to this Fund will also be available for inspection within 10 calendar days after written request at any of the Local Union offices or at the office of any Contributing Employer to which at least 50 Plan Participants report each day.
8. The requirements for eligibility for benefits are set forth on pages 19 - 29 of this SPD and in Article II of the Plan Rules and Regulations, a copy of which is available online at www.norcalaborers.org.



The circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of benefits are set forth on pages 24 - 28 of this SPD and in Article II of the Plan Rules and Regulations.

9. All contributions to the Fund are made by Individual Employers in accordance with collective bargaining agreements in force with the Northern California District Council of Laborers, affiliated Local Union or other entity related to the Fund, with respect to certain of their employees pursuant to Board regulations.
10. Benefits are provided from a trust fund and insurance contracts through Kaiser Foundation Health Plan Northern California Region; UnitedHealthcare Dental, DeltaCare USA and Bright Now! Dental.
11. The end of the year for the purpose of maintaining the Fund's fiscal records is May 31st (the ERISA Plan Year).
12. The procedure for filing claims is set forth on pages 77 - 81.

Statement of Rights under the Employee Retirement Income Security Act ERISA of 1974

As a Participant in the Laborers Health and Welfare Trust Fund for Northern California, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA provides that all Plan Participants are entitled to the following rights:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents governing the Plan. These documents include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor (DOL) and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration). You may also locate a copy of the Form 5500 series on the DOL/EBSA  website: www.dol.gov/ebsa/.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies. You may also locate the Plan's SPD on the Trust Fund's website and the Form 5500 series can be located on the DOL/EBSA  website www.dol.gov/ebsa/.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or Dependent children if there is a loss of coverage under the Plan as a result of a COBRA Qualifying Event - refer to page 30. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules of your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries


In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a welfare benefit is denied, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.



Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a Claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court, once you have exhausted the appeals process described in “Claims and Appeals Procedures” in this SPD. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor (DOL), or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor (DOL), listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at  1-866-444-EBSA (3272) or writing to the following address:



Division of Technical Assistance and Inquiries
Employee Benefits Security Administration (EBSA)
U.S. Department of Labor
200 Constitution Avenue N.W. | Washington, D.C. 20210

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