Laborers Funds Administrative Office of Northern California, Inc.
5672 Stoneridge Drive, Suite 100, Pleasanton, CA 94588 | Telephone: 707-864-2800 or 800-244-4530

Important Announcement

Please provide a copy of this Announcement to your Spouse and eligible children enrolled in the Plan.

Date: June 14, 2023

To: Laborers Health and Welfare Trust Fund for Northern California Active, Retired, and Special Plan Participants and Dependents, Including COBRA Beneficiaries

From: Board of Trustees

Subject: Benefit Improvements to the Health &Welfare Direct Payment Plan and Changes Related to the End of the COVID-19 National Emergency and Public Health Emergency

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This Notice is intended to advise you of certain material modifications that have been made to the Laborers Health and Welfare Trust Fund for Northern California. **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

CHANGES TO ANTHEM BLUE CROSS DENTAL BENEFITS EFFECTIVE May 1, 2023

The Board of Trustees is pleased to advise you that effective for Dental services on or after May 1, 2023, the following dental benefits improvements will apply:

- **Active Plan:** The orthodontia benefit has increased from a lifetime maximum benefit of $3,500 to $4,000.
- **Active and Retiree Plans:** For service on or after June 1, 2022, the dental plans will allow retreatment of root canal procedures.

We are attaching a summary of your dental benefits from Anthem. **Please note there are separate summaries for the Active and Retiree plans.**

Also, effective July 1, 2023, dental services will move from Prime & Complete to the Essential Choice Plan (the provider network is the same). The Anthem Dental Essential Choice plan offers members enhanced dental benefits such as additional cleanings, coverage for veneers and accidental dental injury, and extended age limits on targeted procedures. This will also result in new ID cards being issued and updated benefit summaries being provided.

CHANGES TO THE ANTHEM BLUE VIEW VISION BENEFITS EFFECTIVE MAY 1, 2023

The Board of Trustees is pleased to advise you that your annual allowance for frames has increased from $145 to $200 and your allowance for contact lenses has increased from $120 to $200. We have also added coverage for progressive lenses and anti-reflective coating.

We are attaching a summary of your vision benefits from Anthem. **Please note there are separate summaries for the Active and Retiree plans.**

CLARIFICATIONS TO MEDICAL BENEFITS PURSUANT TO THE END OF THE NATIONAL EMERGENCY (NE) AND PUBLIC HEALTH EMERGENCY (PHE)

This SMM clarifies important changes in COVID-19 related benefits and administrative deadlines as a result of the declared end of the National Emergency and Public Health Emergency on May 11, 2023.

The federal government has announced that both the National Emergency and Public Health Emergency related to COVID-19 will terminate on May 11, 2023. Consequently, the plan rules concerning coverage of certain benefits related to COVID-19 will be changing. In general, special rules in effect during the emergency will terminate and benefits will be covered under the usual cost-sharing provisions of the Welfare Fund.

Changes to COVID-19 Related Benefits

Below, is a brief summary of changes to COVID-19 related medical and prescription drug coverage beginning May 12, 2023:

Benefit	During the Emergency Period	Effective May 12, 2023
COVID-19 vaccines, including boosters	No charge for the vaccine when received at either Participating or Non-Participating Providers.	COVID-19 vaccines and boosters will be covered at no charge when received from a Participating Provider. COVID-19 vaccines and boosters will be covered at out of network cost sharing when received from a Non-Participating Provider.
COVID-19 diagnostic tests and related services	No charge for COVID-19 test related office visits or lab tests (including rapid diagnostic and swab-and-send tests) performed by either Participating or Non-Participating Providers.	COVID-19 test related office visits or lab tests will be covered in the same manner (with the same cost sharing) as any test or lab, based on whether the service is performed by a Participating or Non-Participating Provider.
COVID-19 at-home test kits, also known as over-the-counter, or OTC test kits	No charge for up to eight (8) over-the-counter (OTC) COVID-19 tests per month, both in and out of network. Reimbursement for out-of-network OTC COVID-19 tests is limited to $12 per test.	COVID-19 OTC tests are not covered under the Fund and are not reimbursable.

Elimination of Extended Deadlines for Administrative Actions

In addition to the changes above, there are also certain administrative timeframes that will return to normal after the end of the NE and PHE.

Below, is a brief summary of changes to administrative related deadlines beginning on July 10, 2023, the earlier of 60 days after the announced end of the COVID-19 National Health Emergency, or one year from the deadline for your particular deadline, whichever is earlier.

Administrative Timeframe	During the Emergency Period	Return to Normal Timeframes
COBRA, HIPAA, special enrollment and benefit claims and appeals	During the National Emergency, deadlines for the following events were extended until the earlier of July 10, 2023, or one year from the original deadline: • COBRA elections • Paying COBRA premiums • Electing HIPAA special enrollment • Filing claims, appeals, and requests for external review	Effective July 10, 2023, the deadlines for these events return to their normal timeframes. Please see your Summary Plan Description or contact the Fund Office for details on applicable timeframes.

You are still encouraged to use PPO facilities and PPO providers whenever possible. Please keep this important notice with your Plan Document/Summary Plan Description for easy reference to all Plan provisions. Please review these changes carefully and contact the Fund Office with any questions that you may have.

If you should have questions about this Important Announcement, contact the Trust Fund Office, Monday through Friday, 8:00 AM to 5:00 PM.

Sincerely,

Board of Trustees
Laborers Health and Welfare Trust Fund
for Northern California

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, contact the Trust Fund Office.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan.
Keep this Important Announcement with your Health and Welfare Plan Booklets

Summary of Benefits

Anthem Dental Essential Choice PPO

Laborers Health & Welfare Trust Fund for Northern California

Anthem Blue Cross Dental Complete Network

WELCOME TO YOUR DENTAL PLAN!

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

Powerful and easily accessible member tools.

- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in about 24 hours.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **Mobile Capabilities:** With our latest mobile application, members can find a network dentist as well as view their claims. Our application is available for both Android and Apple phones.

Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.
- To find a dentist by name or location, go to anthem.com or call dental customer service at the number listed on the back of your ID card.

Ready to use your dental benefits?

- Choose a dentist from the network
- Make an appointment
- Show the office staff your member ID card
- Pay any deductible or copay that is part of your plan

Need to contact us?

See the back of your ID card for how to call, write or email us.

Your dental benefits at a glance

The following benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your policy.

	In-Network	Out-of-Network
Coverage Year	Contract Year	
Annual Benefit Maximum • Per insured person • Diagnostic & Preventive Services are not applied to the Annual Benefit Maximum	$2,500	$2,500
Annual Maximum Carryover	No	No
Orthodontic Lifetime Benefit Maximum • Per eligible person	$4,000	$4,000
Annual Deductible • Per insured person • Family maximum	$100 3x single member deductible	$100 3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	90th percentile	

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period

Diagnostic & Preventive Services
• Periodic dental exam
  ○ Limited to two per 12 months
• Teeth cleaning (prophylaxis)
  ○ Limited to four per 12 months; combined with periodontal maintenance
• Bitewing X-rays
  ○ Limited to one set per 12 months
• Full-Mouth or Panoramic X-rays
  ○ Limited to one per 36 months
• Fluoride application
  ○ Limited to one per 12 months through age 18
• Sealant application
  ○ Limited to one per 24 months through age 18
• Consultation (second opinion); only with X-rays and no other services
  ○ Limited to one per 12 months.
• Space maintainer insertion
  ○ Limited to one per tooth space per 12 months through age 18
	100% coinsurance	**100% coinsurance**	**No waiting period**

Basic (Restorative) Services
• Amalgam (silver-colored) filling
  ○ Limited to one per tooth surface per 24 months
• Composite (tooth-colored) filling
  ○ Limited to one per tooth surface per 24 months; posterior (back) fillings not paid as an amalgam (silver-colored filling)
• Brush biopsy (cancer test) covered at Diagnostic/Preventive level
  ○ Limited to one per 12 months; all ages
	70% coinsurance	**70% coinsurance**	**No waiting period**

Endodontics (Non-Surgical) • Root Canal (permanent teeth only) ○ Limited to one per tooth per lifetime	**70% coinsurance**	**70% coinsurance**	**No waiting period**
Endodontics (Surgical) • Apicoectomy and apexification ○ Limited to one per tooth per lifetime; permanent teeth only	**70% coinsurance**	**70% coinsurance**	**No waiting period**

Periodontics (Non-Surgical)
• Periodontal maintenance
  ○ Limited to four per 12 months, combined with teeth cleanings
• Scaling and root planning; when the tooth pocket has a depth of four millimeters or greater
  ○ Limited to one per quadrant per 24 months
	70% coinsurance	**70% coinsurance**	**No waiting period**

Periodontics (Surgical) • Periodontal surgery (osseous, gingivectomy, graft procedures) ○ Limited to one per quadrant per 36 months	**70% coinsurance**	**70% coinsurance**	**No waiting period**
Oral Surgery (Simple) • Simple extraction covered at Basic (Restorative) level ○ Limited to one per tooth per lifetime	**70% coinsurance**	**70% coinsurance**	**No waiting period**
Oral Surgery (Complex) • Surgical extraction ○ Limited to one per tooth per lifetime	**70% coinsurance**	**70% coinsurance**	**No waiting period**
Major (Restorative) Services • Crowns, onlays, veneers ○ Limited to one per tooth per 60 months	**70% coinsurance**	**70% coinsurance**	**No waiting period**

Prosthodontics
• Dentures and bridges
  ○ Limited to one per tooth/arch per 60 months
• Implant placement
  ○ Limited to one per tooth/arch per 60 months
• Implant prosthodontics
  ○ Limited to one per tooth/arch per 60 months; paid as a non-implant crown, bridge, and/or denture
	70% coinsurance	**70% coinsurance**	**No waiting period**

Repairs/Adjustments
• Crown, denture, and bridge repairs
  ○ Limited to one per tooth per 12 months; not within 6 months of placement
• Denture and bridge adjustments
  ○ Limited to two per tooth per 12 months; not within 6 months of placement
	70% coinsurance	**70% coinsurance**	**No waiting period**

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Dental Services (continued)	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Adult/Child Orthodontic Services ○ No age limits apply	50% coinsurance	50% coinsurance	No waiting period
Temporomandibular Joint Disorder (TMJ) • Orthotic devices ○ Covered once per lifetime	70% coinsurance	70% coinsurance	No waiting period
Cosmetic Teeth Whitening ○ Not covered *NOTE: Cosmetic benefits, such as teeth bleaching, in an insurance policy may have income tax implications for both employer groups and plan members. For example, the dollar value of the cosmetic benefit may be considered part of an individual's taxable income. For more information concerning the tax ramifications of cosmetic insurance benefits, please consult a legal or tax advisor.*	Not covered	Not covered	N/A

Additional Services and Programs	
Anthem Whole Health Connection - Dental℠ • For members with certain health conditions, additional dental benefits are available without a deductible or waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable)	Included
Accidental Dental Injury Benefit • Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, member coinsurance, or waiting periods apply	Included
Extension of Benefits • Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered	Included
International Emergency Dental Program • Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, member coinsurance, or waiting periods and won't reduce the member coverage year annual maximum (if applicable)	Included

Additional Limitations & Exclusions

Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

Cosmetic dentistry (unless included as part of you dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There is a 24 month waiting period for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your policy. **In the event of a discrepancy between the information in this summary and the policy, your policy will prevail.**

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Summary of Benefits

Anthem Dental Essential Choice PPO

Laborers Health & Welfare Trust Fund for Northern California-Retirees

Anthem Blue Cross Dental Complete Network

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- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in about 24 hours.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **Mobile Capabilities:** With our latest mobile application, members can find a network dentist as well as view their claims. Our application is available for both Android and Apple phones.

Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.
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Annual Benefit Maximum • Per insured person • Diagnostic & Preventive Services are not applied to the Annual Benefit Maximum	**$2,500**	**$2,500**
Annual Maximum Carryover	**No**	**No**
Orthodontic Lifetime Benefit Maximum • Not applicable	**Not applicable**	**Not applicable**
Annual Deductible • Per insured person • Family maximum	**$50** **3x single member deductible**	**$50** **3x single member deductible**
Deductible Waived for Diagnostic/Preventive Services	**Yes**	**Yes**
Out-of-Network Reimbursement	**90th percentile**	

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  ○ Limited to one per tooth surface per 24 months; posterior (back) fillings not paid as an amalgam (silver-colored filling)
• Brush biopsy (cancer test) covered at Diagnostic/Preventive level
  ○ Limited to one per 12 months; all ages
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Endodontics (Non-Surgical) • Root Canal (permanent teeth only) ○ Limited to one per tooth per lifetime	**70% coinsurance**	**70% coinsurance**	**No waiting period**
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• Implant prosthodontics
  ○ Limited to one per tooth/arch per 60 months; paid as a non-implant crown, bridge, and/or denture
	70% coinsurance	**70% coinsurance**	**No waiting period**

Repairs/Adjustments
• Crown, denture, and bridge repairs
  ○ Limited to one per tooth per 12 months; not within 6 months of placement
• Denture and bridge adjustments
  ○ Limited to two per tooth per 12 months; not within 6 months of placement
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Dental Services (continued)	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Adult/Child Orthodontic Services ○ Not covered	**Not covered**	**Not covered**	**No waiting period**
Temporomandibular Joint Disorder (TMJ) • Orthotic devices ○ Covered once per lifetime	**70% coinsurance**	**70% coinsurance**	**No waiting period**
Cosmetic Teeth Whitening ○ Not covered *NOTE: Cosmetic benefits, such as teeth bleaching, in an insurance policy may have income tax implications for both employer groups and plan members. For example, the dollar value of the cosmetic benefit may be considered part of an individual's taxable income. For more information concerning the tax ramifications of cosmetic insurance benefits, please consult a legal or tax advisor.*	**Not covered**	**Not covered**	**N/A**

Additional Services and Programs	
Anthem Whole Health Connection - Dental℠ • For members with certain health conditions, additional dental benefits are available without a deductible or waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable)	Included
Accidental Dental Injury Benefit • Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, member coinsurance, or waiting periods apply	Included
Extension of Benefits • Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered	Included
International Emergency Dental Program • Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, member coinsurance, or waiting periods and won't reduce the member coverage year annual maximum (if applicable)	Included

Additional Limitations & Exclusions

Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

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Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

Cosmetic dentistry (unless included as part of you dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There is a 24 month waiting period for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your policy. **In the event of a discrepancy between the information in this summary and the policy, your policy will prevail.**

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Blue View VisionSM

Laborers Health & Welfare Trust for Northern California - Active Plan

05.01.2023

Anthem BlueCross

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com/ca**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 copay	Up to $37 reimbursement	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$200 allowance, then 20% off any remaining balance	Up to $40 reimbursement	Once every 24 months
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses:			Once every 12 months
- Single vision lenses	$20 copay	Up to $34 reimbursement	
- Bifocal lenses	$20 copay	Up to $51 reimbursement	
- Trifocal lenses	$20 copay	Up to $68 reimbursement	
- Lenticular lenses	$20 copay	Up to $68 reimbursement	
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
- Transitions Lenses (for a child under age 19)	$0 copay	Up to $5	Same as covered eyeglass lenses
- Standard polycarbonate (for a child under age 19)	$0 copay	Up to $5	
- Factory scratch coating	$0 copay	N/A	
- Oversized	$0 copay	Up to $5	
- Edge Polish	$0 copay	Up to $5	
- Photochromic Glass	$0 copay	Up to $5	
Contact Lenses w/declining balance *(instead of eyeglass lenses)* Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
- Elective conventional (non-disposable)	$200 allowance, then 15% off any remaining balance	Up to $100 reimbursement	Once every 12 months
OR			
- Elective disposable	$200 allowance *(no additional discount)*	Up to $100 reimbursement	
OR			
- Non-elective (medically necessary)	Covered in full	Up to $210 reimbursement	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.

Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his

Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	• Transitions lenses (Adults)
	• Standard Polycarbonate (Adults)
	• Tint (Solid and Gradient)
	• UV Coating
	• Progressive Lenses[1]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	  • Premium Tier 3
	  • Premium Tier 4
	• Anti-Reflective Coating[2]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	  • Premium Tier 3
	• Other Add-ons
		$65
		$30
		$0
		$15
		
		$55
		$75
		$85
		$100
		$175
		
		$35
		$47
		$58
		$85
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	• Complete Pair • Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	• Standard contact lens fitting[3] • Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	• Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.
[2] Please ask your provider for his/her recommendation as well as the available coating brands by tier.
[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.
[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *
Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just **log in at anthem.com/ca**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com/ca**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at **1-866-723-0515** to request a claim form.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com

To Mail: Blue View Vision
Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111

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Blue View Vision[SM]

Laborers Health & Welfare Trust for Northern California - Retired Plan

05.01.2023

Anthem BlueCross

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com/ca**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 copay	Up to $37 reimbursement	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$200 allowance, then 20% off any remaining balance	Up to $40 reimbursement	Once every 12 months
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses:			Once every 12 months
• Single vision lenses	$10 copay	Up to $34 reimbursement	
• Bifocal lenses	$10 copay	Up to $51 reimbursement	
• Trifocal lenses	$10 copay	Up to $68 reimbursement	
• Lenticular lenses	$10 copay	Up to $68 reimbursement	
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
• Transitions Lenses (for a child under age 19)	$0 copay	Up to $5	Same as covered eyeglass lenses
• Standard polycarbonate (for a child under age 19)	$0 copay	Up to $5	
• Factory scratch coating	$0 copay	N/A	
• Oversized	$0 copay	Up to $5	
• Edge Polish	$0 copay	Up to $5	
• Photochromic Glass	$0 copay	Up to $5	
Contact Lenses w/declining balance *(instead of eyeglass lenses)* Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
• Elective conventional (non-disposable)	$200 allowance, then 15% off any remaining balance	Up to $100 reimbursement	Once every 12 months
OR			
• Elective disposable	$200 allowance *(no additional discount)*	Up to $100 reimbursement	
OR			
• Non-elective (medically necessary)	Covered in full	Up to $210 reimbursement	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.

Excess Amounts. Amounts in excess of covered vision expense.

Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.

Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than $39
Eyeglass lens upgrades When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	Standard Polycarbonate (Adults)	$30
	Tint (Solid and Gradient)	$0
	UV Coating	$15
	Progressive Lenses[1]	
	Standard	$55
	Premium Tier 1	$75
	Premium Tier 2	$85
	Premium Tier 3	$100
	Premium Tier 4	$175
	Anti-Reflective Coating[2]	
	Standard	$35
	Premium Tier 1	$47
	Premium Tier 2	$58
	Premium Tier 3	$85
	Other Add-ons	20% off retail price
Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	Complete Pair	40% off retail price
	Eyeglass materials purchased separately	20% off retail price
Eyewear Accessories	Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	Standard contact lens fitting[3]	Up to $55
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To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111