

TO: All Eligible Retired Participants and Their Dependents

RE: Comparison of Medical-Hospital Plans - Effective March 1, 2024

The Laborers Health and Welfare Trust Fund for Northern California ("Fund") offers three (3) Medical-Hospital Plans ("Medical Plan") to Retired Participants and their eligible dependents who have satisfied the eligibility requirements of the Retired Laborers Plan ("Plan"). As a Retired Participant, you are allowed to: (1) initially enroll in one of the Medical Plans listed below, and (2) change Medical Plans up to a maximum of two times per calendar year.

- 1. Laborers Direct Payment Plan (provides medical and prescription drug coverage) for both Non-Medicare and Medicare eligible individuals. This is a <u>P</u>referred <u>P</u>rovider <u>O</u>rganization (PPO) plan. This Medical Plan provides traditional fee-for-service benefits. You are allowed to use any provider but using participating hospitals and providers (PPO) may lower your out-of-pocket costs.
- 2. Kaiser Permanente Plan (provides medical and prescription drug coverage) for both Non-Medicare and Medicare eligible individuals. This is a <u>H</u>ealth <u>M</u>aintenance <u>O</u>rganization (HMO) plan. Kaiser provides benefits at no cost or with limited copayments to you, however, your choice is limited to Kaiser approved physicians and facilities only. If you choose Kaiser, you and your dependents, with or without Medicare, must all enroll in Kaiser.
- 3. Anthem Blue Cross Medicare Advantage Plan (provides medical and prescription drug coverage) for <u>Medicare</u> eligible individuals only. This is a Medicare Advantage PPO plan. You have the freedom to see any Medicare providers in all 50 states and 5 U.S territories, as long as the provider accepts Medicare and the plan. There are no copayments or coinsurance in this plan. It covers all benefits under Original Medicare Parts A and B plus additional benefits not covered under Medicare.

Enclosed is a Comparison and Summary of Medical Plans that describes in summary the type of service, how much each Medical Plan covers and your out-of-pocket cost. The Comparison has been designed to help you understand the difference between the Medical Plans so that you can decide which Plan suits your entire family's health care needs. We urge you to review the Comparison and the Monthly Self-Payment Rates **before** selecting a Medical Plan (see page 2). Again, you are allowed to switch Medical Plans no more than twice per calendar year. To switch to another Medical Plan, request a Medical Plan Election form from the Fund Office, your Local Union or go to the Trust Fund website, www.lfao.org, to print or order the form. If you are eligible to enroll in the optional Dental and Vision Plans, please refer to the Comparison for Dental and Vision Plans.

Regardless of what Medical Plan you choose, **you are required to complete a Medical Plan Election form**. You must also complete a <u>K</u>aiser <u>P</u>ermanente <u>S</u>enior <u>A</u>dvantage (KPSA) election form or Anthem Blue Cross Medicare Advantage Plan Enrollment Election form for each Medicare eligible individual enrolling in Kaiser or Anthem Medicare Plan. All required forms to enroll in a Medical Plan must be mailed back directly to the Fund Office at the above address – <u>do not</u> mail any of the forms directly to Kaiser Permanente or Anthem Blue Cross.

It is important that you notify the Fund Office immediately if the following event occurs: (1) you or any of your enrolled dependents become eligible for Medicare, or (2) you want to delete an existing dependent from or add a new dependent to your Medical Plan such as your spouse or child. If you fail to notify the Fund Office of a change to Medicare eligibility or dependent status, it may result an overpayment or underpayment of your medical claims and/or monthly premium that you pay for coverage. An Enrollment Form is required to add or delete a dependent. You may obtain an Enrollment Form by either visiting the Fund Office or any Local Union office, calling the Fund Office to request a form be mailed to you or printing a form by visiting the Trust Funds' website at www.lfao.org.

If you need more information or have any questions, please do not hesitate to contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES



MONTHLY SELF-PAYMENT RATES FOR MEDICAL, DENTAL AND VISION COVERAGE

March 1, 2024

- 1. MEDICAL PLAN (including Prescription Drug benefits) The Fund offers the following three Medical Plans: (1) Laborers Direct Payment Plan, (2) Kaiser Permanente Plan, (3) Anthem Blue Cross Medicare Advantage Plan. Please note that the Anthem Blue Cross Medicare Advantage Plan is for Medicare eligible individuals only. If only you or your spouse has Medicare and the other is Non-Medicare, the Medicare eligible individual may elect Anthem's Medicare Advantage Plan, but the Non-Medicare individual must enroll in the Laborers Direct Payment Plan. If you both have Medicare, you are allowed to split Medical Plans, meaning you may enroll in Anthem's Medicare Advantage Plan and your spouse in Laborers Direct Payment Plan (or vice versa). You pay 100% of the rate shown in the table below for the Medical Plan coverage that you elect unless you are entitled to a 25% or 50% Subsidy based upon the following criteria:
 - 50% Subsidy (you pay 50% of the rate shown) If you are age 55 or over (age 55 means the month following your 55th birthday) and earned 25 Years of Credited Service, or regardless of age and Years of Credited Service, you were approved for a Disability Pension based on a Social Security Disability Award, or regardless of Years of Credited Service, you are age 70 (age 70 means the month following your 70th birthday).
 - **25% Subsidy (you pay 75% of the rate shown)** If you are age 55 or over and earned 10 24 Years of Credited Service.
- 2. DENTAL PLAN The Fund offers the following 2 Dental Plans: Anthem Blue Cross Dental Complete and DeltaCare USA.
- 3. VISION PLAN The Fund offers the following 2 Vision Plans: Anthem Blue Cross Blue View Vision and Kaiser Vision Essentials

IMPORTANT: Self-Payment Rates are subject to change every March 1. The Subsidy **does not apply** to Dental and Vision Plans.

	Medica	I Plan (including Prescrip	tion Drug benefits)		Dentel Dien	
	Direct Pay	Anthem	Kaiser Pe	ermanente	Dental Plan	Vision Plan
TYPE OF	Laborers Direct Payment Plan for Non-Medicare Individuals	Anthem Blue Cross Medicare Advantage for Medicare Individuals	Kaiser	Kaiser Permanente	Vou pay 100% o	f the rate shown
COVERAGE	*No cost (co-pays; coinsurance; deductible) to Medicare individuals. Covers <u>all services</u> <u>covered by the Retired Plan</u> , even if Medicare does not	<u>Important</u> – only covers Medicare covered services	Permanente for Non-Medicare Individuals	Senior Advantage for Medicare Individuals	e You pay 100% of the rate sh below PLUS the rate for t Medical Plan that you elec	
One Medicare	\$374	\$311		\$347	Regardless of	Regardless of
	\$733	\$622			family size,	family size, the
Two Medicare	\$685 (one is enrolled in Labor is enrolled in A Cross Medicare A	Anthem Blue		\$694	the monthlymonthlypremium ispremium is tthe same.same.	
One Non-Medicare	\$1,375		\$1,412		Anthem Dental	
Two Non-Medicare	\$2,731		\$2,824		\$75	Anthem Vision
One Medicare and One Non-Medicare		\$1,686 (Non-Medicare individuals must enroll	\$1	,759	DeltaCare USA	\$9 *//aiaan//iaian
One Medicare and Two Non-Medicare	\$1,749	in Laborers Direct Payment Plan)	\$2	,818	\$40	*Kaiser Vision \$4
Family (3 or more) If your family mix is different from above, call the Fund Office for the specific rates.	\$2,731 Non-Medicare Family		\$3,881 Non-Medicare Family	\$1,041 for 3 Medicare Individuals (Non-Medicare individuals may enroll in Kaiser Non-Medicare Plan)		* - if you are enrolled in the Laborers Direct Payment Plan, you are not allowed to choose Kaiser Vision.



MEDICAL-HOSPITAL-PRESCRIPTION DRUGS BENEFITS COMPARISON AND SUMMARY OF MEDICAL PLANS

March 1, 2024

General Information	Laborers Direct Payment Plan for Non-Medicare Individuals	Anthem Blue Cross Medicare Advantage	Kaiser Permanente	Kaiser Permanente Senior Advantage
Information	*No cost (co-pays; coinsurance; deductible) to Medicare individuals	for Medicare Individuals	for Non-Medicare Individuals	for Medicare Individuals
Type of Plan	The Direct Payment Plan provides traditional, fee-for- service medical benefits and offers higher coverage when you use Anthem Blue Cross participating hospitals and providers (PPO).	Care is provided through physicians or medical staff that accept Medicare and the plan.	Care is provided through physicians or medical staff at a Kaiser Permanente facility located in the member's service area.	Care is provided through physicians or medical staff at a Kaiser Permanente facility located in the member's service area. Medicare will not pay for or provide benefits for services received outside the Kaiser's Medicare Program.
Geographical Area Covered	Expenses incurred outside the United States and its Territories are covered if due to Emergency Services. If the expense is covered, normal benefits will apply.	Coverage in Anthem's CMS-defined geographic service area of all 50 states, Washington, D.C., and five U.S. territories.	You must reside within Kaiser Service Area, usually within California. If you have any question whether your residence address is a Kaiser Service Area, contact the Trust Fund Office.	
Choice of Physicians	Unlimited. Use of Anthem Blue Cross participating physicians result in lower out-of-pocket expenses.	Freedom to choose providers who accept Medicare and the plan, nationwide, without a referral.	Each member may use any Kaiser Permanente Physician.	
Specialized Care: In-Network	You select any specialist.	You select any specialist.	Self-referral to specialists such as optometry, chemical dependency, psychiatry, and OB/Gyn. Your Kaiser Permanente physician refers you to other specialists.	
Outside Network	You select any specialist.	You select any specialist.	An outside specialist requires specific referral from your Plan Physician. Cost Sharing is consistent with Plan coverage required for services if provided by a Plan Provider or referred by a Kaiser Permanente Physician.	
Out-of-Area Care	Out of network benefits apply to treatment anywhere in the United States, its territories, and possessions. Services outside United States may be covered if due to emergency.	Out of network benefits apply to treatment anywhere in the United States, its territories, and possessions. Urgent and emergency services outside United States are covered.	and subject to authorization.	
Lifetime Benefit Maximum	\$750,000 per individual, \$2,000 reinstatement per Plan Year.	None.	None. Some restrictions apply. \$1,5 up to \$3,000 per family per calenda	00 maximum out-of-pocket per individual r year.

General Information	Laborers Direct Payment Plan for Non-Medicare Individuals *No cost (co-pays; coinsurance; deductible) to Medicare individuals	Anthem Blue Cross Medicare Advantage for Medicare Individuals	Kaiser Permanente for Non-Medicare Individuals	Kaiser Permanente Senior Advantage for Medicare Individuals
Annual Deductible	 \$150 per individual, maximum of \$450 per family per Plan Year (March 1 – February 28). Does not apply to Inpatient Hospital, Physical Exam, Preventive Services, Urgent Care Services and Prescription Drug benefits. Deductible amount applied in December, January and February will be carried forward to following Plan Year. 	None.	None.	
Out-of-Pocket Annual Maximum Medical & Hospital Expenses Only	\$3,000 per individual, maximum of \$6,000 per family per Plan Year. Includes your deductible, coinsurance and copayments for charges by PPO providers only. Does not include your coinsurance to Non-PPO providers, penalties for not using a PPO hospital or not obtaining a pre-admission review for admission to a Non-PPO hospital, Plan exclusions and limitations.	\$0	For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pa for those Services add up to the following amount: for any one Member = \$1,500 per calendar year.	
Inpatient Hospital Medical/Surgery Mental Health	Not subject to Deductible. PPO Hospital - 90% of 1st \$10,000 and 100% thereafter of negotiated rates. Non-PPO Hospital - 70%* of 1st \$10,000 and 100% thereafter of allowed charges. * - 90% if emergency admission or patient resides outside California.	No charge.	Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services) - No charge.	
Total Hip or Knee Replacement Surgery	Same as Medical/Surgery above but not to exceed \$30,000 Maximum Plan Allowance. Higher out-of- pocket costs if you do not use a Value-Based Site hospital approved by the Plan.	No charge.	Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort - \$10 per procedure.	
Skilled Nursing Facility/ECF	Same as Medical/Surgery above.	No charge.	Skilled nursing facility services up to charge.	o 100 days per benefit period - No

General	Laborers Direct Payment Plan for Non-Medicare Individuals	Anthem Blue Cross Medicare Advantage	Kaiser Permanente	Kaiser Permanente Senior Advantage
Information	*No cost (co-pays; coinsurance; deductible) to Medicare individuals	for Medicare Individuals	for Non-Medicare Individuals	for Medicare Individuals
Alcohol and Substance Abuse	Same as Medical/Surgery on previous page.	No charge.	Inpatient detoxification - No charge. Individual outpatient substance use disorder evaluation and treatment - per visit. Group outpatient substance use disorder treatment - \$5 per visit.	
Utilization Review	Automatic part of Plan procedures. Required for most hospital stay.	Automatic part of Plan procedures.	Automatic part of Plan procedures.	
	Up to \$2,000 penalty for non-compliance if admitted to Non-PPO Hospital.			
Medical Care Outpatient Hospital	Subject to Deductible. PPO Hospital - 90% of negotiated rates. Non-PPO Hospital - 70% of allowed charges.	No charge.	Outpatient surgery and certain other outpatient procedures -\$10 per procedure.	
Emergency Room Outpatient Hospital	Subject to Deductible. \$25 copayment each for visits 1, 2 and 3, \$50 each visit thereafter per calendar year whether PPO or Non-PPO Hospital is used PPO Hospital - 90% of negotiated rates. Non-PPO Hospital - 70% of allowed charges. Copayment waived under certain circumstances.	No charge.	\$50 copayment per visit. Copaymer	it waived if admitted.
Urgent Care Facility Services	Not subject to Deductible. PPO Hospital - 90% of negotiated rates. Non-PPO Hospital - 70% of allowed charges.	No charge.	Urgent Care visits - \$10 per visit.	
Arthroscopic, Cataract or Colonoscopy Procedure Facility Charges	Subject to Deductible. PPO Hospital - 90%* of negotiated rates. Non-PPO Hospital - 70%* of allowed charges. * - Subject to Maximum Plan Allowance (MPA): Arthroscopy \$6,000 Cataract \$2,000 * Colonoscopy \$1,500 Exception: MPA does not apply if a Value- Based Site facility is used.	No charge.	Outpatient surgery and certain othe procedure.	er outpatient procedures - \$10 per

General Information	Laborers Direct Payment Plan for Non-Medicare Individuals *No cost (co-pays; coinsurance; deductible) to Medicare individuals	Anthem Blue Cross Medicare Advantage for Medicare Individuals	Kaiser Permanente for Non-Medicare Individuals	Kaiser Permanente Senior Advantage for Medicare Individuals
Ambulatory Surgery Center	Subject to Deductible. PPO Facility - 90% of negotiated rates. Non-PPO Facility - \$500 Maximum Plan Allowance	No charge.	Outpatient surgery and certain other or procedure.	outpatient procedures - \$10 per
Home Health Care	Subject to Deductible. 90% of covered charges. Only upon referral by Case Management.	No charge.	Home health care Services (Up to 2 ho maximum/day, up to 100 visits maxim	· · · ·
Hospice Care	Subject to Deductible. 90% of covered charges. Only upon referral by Case Management.	Covered by Original Medicare	No charge.	
Physician Fees: Office Visits	Subject to Deductible and \$15 copayment per visit. PPO Physician - 100% negotiated rate. Non-PPO Physician - 70% allowed charge.	No charge.	\$10 per visit.	
Electronic/Online Telehealth		Including medical, mental health and substance abuse exams. You can use a physician through LiveHealth Online or through your primary doctor. 100% of allowed charge, no Deductible and Copayment.	Primary Care Visits and Non-Physician Specialist Visits - No charge. Physician Specialist Visits - No charge.	
Surgery	Subject to Deductible. PPO Physician - 90% of negotiated rate. Non-PPO Physician - 70% of allowed charge.	No charge.	Outpatient surgery and certain other outpatient procedures - \$10 per procedure.	
Emergency Room Physician	Subject to Deductible. PPO Physician - 90% of negotiated rate. Non-PPO Physician - 90% of allowed charge.	No charge.	Emergency Department Visits - \$50 per visit.	
Preventive Services	Preventive Services or procedures as identified by Patient Protection and Affordable Care Act of 2010. PPO Providers only - No cost sharing (Deductible, Copayment and Coinsurance) by the Participant, 100% payable.	No charge.	Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays: No charge.	

General Information	Laborers Direct Payment Plan for Non-Medicare Individuals *No cost (co-pays; coinsurance; deductible) to Medicare individuals	Anthem Blue Cross Medicare Advantage for Medicare Individuals	Kaiser Permanente for Non-Medicare Individuals	Kaiser Permanente Senior Advantage for Medicare Individuals
Physical Exam and Well Baby	Physical Exam, Well Baby, Laboratory or Radiology by Non-PPO Providers will be paid at normal Plan benefits level with cost sharing by the Participant.	No charge.	Routine physical exams, including well-woman and preventive exams for Members age 2 and older - \$10 per visit.	Annual Wellness visit and the "Welcome to Medicare" preventive visit - No charge.
	Not subject to Deductible and Physician Office Visit copayment.		Well-child preventive exams for Members through age 23 months - \$5 per visit.	
	Maximum Plan Allowance: Participant or Spouse - \$300 per exam. Child older than age 2 - \$200 per exam.			
	Well Baby charges for dependent children up to age 2 are payable as routine office visit and not subject to \$200 maximum per exam.			
Immunizations	Subject to Deductible.	Medicare-covered Part B	Immunizations (including the vaccine	e) administered to you in a Plan Medical
Inoculations	PPO Provider - 90% of negotiated rate. Non-PPO Provider - 70% of allowed charge. *Shingles Vaccine - covered.	vaccinations - No charge. *Shingles Vaccine - Not covered under Medical but covered under	Office - No charge.	
	Similares vacence severeal	pharmacy.		
Substance Abuse Outpatient	Subject to Deductible and \$15 copayment per visit. PPO Physician - 100% of negotiated rate. Non-PPO Physician - 70% allowed charge.	Inpatient detoxification - No charge. Individual outpatient substance use disorder evaluation and treatment - No charge. Group outpatient substance use disorder treatment - No charge.	Individual outpatient substance use disorder evaluation and treatment - \$10	
Mental Health Outpatient	Subject to Deductible and \$15 copayment per visit. PPO Physician - 100% negotiated rate. Non-PPO Physician - 70% allowed charge.	Inpatient psychiatric hospitalization - No charge. Individual outpatient mental health evaluation and treatment - No charge. Group outpatient mental health treatment - No charge.	Individual outpatient mental health evaluation and treatment - \$10 per visit.	
Smoking Cessation	Subject to Deductible and \$15 copayment per visit. PPO Physician - 100% negotiated rate. Non-PPO Physician - 70% allowed charge.	Medicare-covered smoking and tobacco use cessation preventive benefits - No charge.	Individual counseling during an offic charge.	e visit related to smoking cessation - No

General Information	Laborers Direct Payment Plan for Non-Medicare Individuals *No cost (co-pays; coinsurance; deductible) to Medicare individuals	Anthem Blue Cross Medicare Advantage for Medicare Individuals	Kaiser Permanente for Non-Medicare Individuals	Kaiser Permanente Senior Advantage for Medicare Individuals
Lab Test, X-Ray, MRI, CT Scan	Subject to Deductible. PPO Provider - 90% of negotiated rate Non-PPO Provider - 70% of allowed charge	No charge.	No charge.	
Chiropractic Benefits	Subject to Deductible. Maximum Plan Allowance: Up to 20 visits per Plan Year. PPO Provider - 100% of negotiated rate. Non-PPO Provider - 70% of allowed charge.	For Medicare non-covered chiropractic services rendered by a physician to treat a disease, illness or injury - No charge, limited to 20 visits per year combined in-network and out-of- network.	Not covered.	
Physical Therapy	Subject to Deductible. PPO Provider - 90% of negotiated rate. Non-PPO Provider - 70% of allowed charge.	Medicare-covered physical therapy, occupational therapy, and speech language therapy visits - No charge.	Outpatient physical, occupational, and speech therapy - Individual \$10 visit, Group \$5 per visit. Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program - \$10 per day.	
Nutritional Health Dietary Counseling	Subject to Deductible. Subject to \$15 Physician Office Visit copayment if billed as office visit. PPO Provider - 90% of negotiated rate. 100% for office visit. Non-PPO Provider - 70% of allowed charge.	Medicare-covered health education programs, which may include programs provided online and counseling over the phone - No charge.	Covered health education progra provided online and counseling o	
Durable Medical Equipment	Subject to Deductible. Rx required from a physician. PPO Provider - 90% of negotiated rate. Non-PPO Provider - 70% of allowed charge.	Medicare-covered durable medical equipment - No charge.	Covered durable medical equipm	ent for home use - No charge.
Ambulance	Subject to Deductible. Air ambulance covered if life threatening condition. PPO Provider - 90% of negotiated rate. Non-PPO Provider - 70% of allowed charge or 90% if life threatening condition.	No charge.	No charge.	
Hearing Aids Device	Subject to Deductible. Maximum Plan Allowance: \$1,200 per ear/device per 36 months.	Hearing aids are limited to a \$1,500 maximum benefit every 24 months combined in-network and out-of-network. Includes digital hearing aid technology and inner ear, outer ear, and over the ear models. Fitting adjustment after hearing aid is received, if necessary.	 inspection - Not covered. Hearing exams with an audiologist to determine the need for hearing correction - \$10 per visit. 	

Laborers Direct Payment Plan	Anthem Blue Cross	Kaiser Permanente	Kaiser Permanente
for Medicare and	Medicare Advantage	for Non-Medicare Individuals	Senior Advantage
Non-Medicare Individuals	for Medicare Individuals		for Medicare Individuals
	PRESCRIPTION DRI		
CarelonRx benefits provided through Fund whether Pharmacy.		You pay the copayment per prescription below at Kaiser Permanente pharmacies; up to a 100- day supply of generic or medically necessary	You pay the copayment per prescription below for covered drugs in accordance with Health Plan Formulary guidelines.
CONTRACTING PHARMACY: You pay the copayment	per prescription below.	prescribed brand name drugs in accordance with Health Plan Formulary guidelines.	Prescriptions written by non-Kaiser physicians are not covered.
<u>Retail</u> 30 day supply maximum per prescription:			<u>At a Kaiser Pharmacy</u>
Generic - \$10 * Formulary Brand Name - \$20. Non Mail Order	-Formulary Brand Name - \$30.	Generic - \$5.	Generic: \$5 for up to 30 day supply.
90 day supply maximum per prescription:			\$10 for 31 - 60 day supply.
Generic - \$20 * Formulary Brand Name - \$40. Non	-Formulary Brand Name - \$60.		\$15 for 61 - 100 day supply.
Mail Order is mandatory for maintenance drugs afte	r 3 fills.		
		Brand Name - \$15.	Brand Name and specialty drugs:
If a generic equivalent is available but you prefer Bra	nd Name, you will pay for the difference in cost		\$10 for up to 30 day supply.
between the generic and Brand Name drug.			\$20 for 31 - 60 day supply.
			\$30 for 61 - 100 day supply.
Maximum: \$35,000 maximum payable per individual	l, per calendar year for combined retail and mail		
order.			<u>Mail Order</u>
Out of Declart Maximum for Contracting Discussion	un lu		Generic:
Out-of-Pocket Maximum for Contracting Pharmacy c \$3,000 per person up to \$6,000 per family, per calen			\$5 for up to 30 day supply.
drugs that are excluded by the Plan and penalties for			\$10 for 31 - 100 day supply. Brand Name and specialty drugs:
Program.			\$10 for up to 30 day supply.
			\$20 for 31 - 100 day supply.
NON-CONTRACTING PHARMACY: You pay the full co	st and submit a Reimbursement Form to CarelonRx.		
You will be reimbursed based upon the contract rate			
copayment and other costs	G , (F		
described above. NO OUT-OF-POCKET MAXIMUM.			

Telephone Numbers and (Website Addresses

Laborers Direct Payment Plan (Laborers Fund Administrative Office): 1-800-244-4530 or 1-707-864-2800 | www.lfao.org Anthem Blue Cross Medicare Advantage Plan: 1-833-848-8729 | www.anthem.com/ca | When calling, refer to Group Number CAEGR010 Kaiser Permanente: 1-800-464-4000 (English) or 1-800-788-0616 (Spanish) | www.kaiserpermanente.org | When calling, refer to Group Number 603307

This Comparison and Summary of Medical Plans is intended only as a summary of the benefits provided by each Plan. All exclusions and limitations of benefit coverage have not been included and may vary slightly from Plan to Plan. The contents of this Comparison are not to be construed or accepted as a substitute for the provisions of the Retired Laborers Direct Payment Plan's Rules and Regulations, Anthem Blue Cross Medicare Advantage or Kaiser Permanente's contract.



DENTAL BENEFITS COMPARISON AND SUMMARY OF DENTAL PLANS

Plan Features	Anthem Blue Cross Dental Complete	DeltaCare USA
Monthly Premium	\$75 regardless of family size	\$40 regardless of family size
Annual Deductible	\$50 per person \$150 per family maximum Diagnostic and Preventive Services are NOT subject to the Deductible	None
Annual Benefit Maximum	\$2,500 per person Diagnostic and Preventive Services are NOT applied to the Annual Benefit Maximum	No maximum
Participant Coinsurance (Your portion)	Diagnostic and Preventive Services: 0% Basic & Major Services: 30% Endodontics & Periodontics: 30% Prosthodontics & Oral Surgery: 30%	Varying copayments
Orthodontic Benefits	Not covered	Participant Copayments: Start-Up Fee: \$350 Treatment for Adult: \$1,800 Treatment for Child: \$1,600

Telephone Numbers and (Website Addresses

Anthem Blue Cross Dental Complete: 1-877-567-1804 * www.anthem.com/ca/mydentalvision

DeltaCare USA: 1-800-422-4234 * www.deltadentalins.com

This Comparison and Summary of Dental Plans is intended only as a summary of the benefits provided by each Plan. All exclusions and limitations of benefit coverage have not been included and may vary slightly from Plan to Plan. The contents of this Comparison are not to be construed or accepted as a substitute for the provisions of the Anthem Blue Cross Dental Complete or DeltaCare USA contract.



VISION BENEFITS COMPARISON AND SUMMARY OF VISION PLANS

Anthem Blue Cross Blue View Vision (Monthly Premium: \$9)					
Covered Benefit and	IN-NET				
Frequency Limitation	Plan Allowance	Your Copayment	NON-NETWORK PROVIDER		
Routine Eye Exam Every 12 months	Covered in full	\$10	\$37 allowance only		
Eyeglass Frame Every 12 months	\$200	You pay the balance after \$200 allowance less 20% discount	\$40 allowance only		
Eyeglass Standard Lenses Every 12 months 1 pair only of Single, Bifocal, Trifocal or Lenticular lenses	Covered in full	\$10 (1 pair limit)	\$34 to \$68 allowance only depending on type of lenses		
Contact Lenses (Conventional) Every 12 months	\$200	You pay the balance after \$200 allowance less 15% discount	\$100 allowance only		

Kaiser Vision Essentials (Monthly Premium: \$4)				
Covered Benefit and	A	T KAISER PERMANENTE OPTICAL CI	ENTERS	
Frequency Limitation	Plan Allowance	Your Copayment	Notes	
Routine Eye Exam <i>No limit</i>	Covered in full	\$10	No copayment for preventive screenings	
Eyeglass Frame Every 24 months	\$145	You pay the balance after \$145 allowance	Fashionable frames priced between \$40 to \$99	
Eyeglass Standard Lenses Every 12 months	Cov	1 pair only of clear plastic, single, flat-top multifocal or lenticular lenses		
Contact Lenses (Conventional) Every 12 months	\$120	You pay the balance after \$120 allowance	Order refills online at www.kp2020.org/noca	

Telephone Numbers and 🕐 Website Addresses

Anthem Blue Cross Blue View Vision: 1-866-723-0515 * www.anthem.com/ca

Kaiser Vision Essentials: 1-800-464-4000 * www.kaiserpermanente.org

This Comparison and Summary of Vision Plans is intended only as a summary of the benefits provided by each Plan. All exclusions and limitations of benefit coverage have not been included and may vary slightly from Plan to Plan. The contents of this Comparison are not to be construed or accepted as a substitute for the provisions of the Anthem Blue Cross Blue View Vision or Kaiser Vision Essentials contract.