



Laborers Funds Administrative Office of Northern California, Inc.

5672 Stoneridge Drive, Suite 100, Pleasanton, CA 94588 | Telephone: 707-864-2800 or 800-244-4530

TO: All Eligible Retired Participants and Their Dependents
RE: Comparison of Medical-Hospital Plans - Effective March 1, 2026

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 Preferred Provider Organization (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 Health Maintenance Organization (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 Medicare 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 Kaiser Permanente Senior Advantage (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 – **do not 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

Revised 01/06/2026

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.

| TYPE OF COVERAGE | Medical Plan (including Prescription Drug benefits) | | | | Dental Plan | Vision Plan |
|---|---|--|--------------------------------|--|---|---|
| | Direct Pay | Anthem | Kaiser Permanente | | | |
| Laborers Direct Payment Plan for Non-Medicare Individuals | | Anthem Blue Cross Medicare Advantage for Medicare Individuals | | | | |
| *No cost (co-pays; coinsurance; deductible) to Medicare individuals. Covers <u>all services covered by the Retired Plan, even if Medicare does not</u> | | Important – only covers Medicare covered services | | | | |
| One Medicare | \$417 | \$332 | | \$421 | Regardless of family size, the monthly premium is the same. | Regardless of family size, the monthly premium is the same. |
| Two Medicare | \$818 | \$664 | | \$841 | Anthem Dental \$85 | Anthem Vision \$16 |
| | \$685 (one is enrolled in Laborers Plan and the other one is enrolled in Anthem Blue Cross Medicare Advantage Plan) | | | | DeltaCare USA \$43 | *Kaiser Vision \$12 |
| One Non-Medicare | \$1,499 | | \$1,636 | | | |
| Two Non-Medicare | \$2,980 | | \$3,273 | | | |
| One Medicare and One Non-Medicare | \$1,916 | \$1,831 (Non-Medicare individuals must enroll in Laborers Direct Payment Plan) | \$2,057 | | | |
| One Medicare and Two Non-Medicare | | | \$3,364 | | | |
| Family (3 or more) If your family mix is different from above, call the Fund Office for the specific rates. | \$2,980 Non-Medicare Family | | \$4,580 Non-Medicare Family | \$1,263 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. |



| 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 |
|-------------------------------------|---|--|---|---|
| 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. | Cost Sharing for Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care from a Non-Plan Provider is the Cost Sharing for a plan provider and subject to authorization. | |
| Lifetime Benefit Maximum | \$750,000 per individual, \$2,000 reinstatement per Plan Year. | None. | None. Some restrictions apply. \$1,500 maximum out-of-pocket per individual up to \$3,000 per family per calendar 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 | <p>\$150 per individual, maximum of \$450 per family per Plan Year (March 1 – February 28).</p> <p>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.</p> | None. | None. | |
| Out-of-Pocket Annual Maximum Medical & Hospital Expenses Only | <p>\$3,000 per individual, maximum of \$6,000 per family per Plan Year.</p> <p>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.</p> | \$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 pay for those Services add up to the following amount: for any one Member = \$1,500 per calendar year. | |
| Inpatient Hospital Medical/Surgery Mental Health | <p>Not subject to Deductible.</p> <p>PPO Hospital - 90% of 1st \$10,000 and 100% thereafter of negotiated rates.</p> <p>Non-PPO Hospital - 70%* of 1st \$10,000 and 100% thereafter of allowed charges. * - 90% if emergency admission or patient resides outside California.</p> | 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 | <p>Same as Medical/Surgery above but not to exceed \$30,000 Maximum Plan Allowance.</p> <p>Higher out-of-pocket costs if you do not use a Value-Based Site hospital approved by the Plan.</p> | 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 100 days per benefit period - No charge. | |

| General Information | Laborers Direct Payment Plan for Non-Medicare Individuals | Anthem Blue Cross Medicare Advantage for Medicare Individuals | Kaiser Permanente for Non-Medicare Individuals | Kaiser Permanente Senior Advantage for Medicare Individuals |
|--|--|---|--|---|
| | *No cost (co-pays; coinsurance; deductible) to 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 - \$10 per visit. Group outpatient substance use disorder treatment - \$5 per visit. | |
| Utilization Review | Automatic part of Plan procedures. Required for most hospital stay. Up to \$2,000 penalty for non-compliance if admitted to Non-PPO Hospital. | Automatic part of Plan procedures. | Automatic part of Plan procedures. | |
| 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, \$200 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. Copayment 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 other outpatient procedures - \$10 per procedure. | |

| 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 outpatient procedures - \$10 per procedure. | |
| 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 hours maximum/visit, up to 3 visits maximum/day, up to 100 visits maximum/year) - No charge. | |
| 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 must use a physician through LiveHealth Online or Transcarent (non-Medicare individuals). 100% of allowed charge, no Deductible and Copayment. | 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. | Telehealth Visits – Interactive video visits or scheduled telephone visits: 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 | <p>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.</p> <p>Not subject to Deductible and Physician Office Visit copayment.</p> <p>Maximum Plan Allowance: Participant or Spouse - \$300 per exam. Child older than age 2 - \$200 per exam.</p> <p>Well Baby charges for dependent children up to age 2 are payable as routine office visit and not subject to \$200 maximum per exam.</p> | No charge. | <p>Routine physical exams, including well-woman and preventive exams for Members age 2 and older - \$10 per visit.</p> <p>Well-child preventive exams for Members through age 23 months - \$5 per visit.</p> | Annual Wellness visit and the "Welcome to Medicare" preventive visit - No charge. |
| Immunizations Inoculations | <p>Subject to Deductible. PPO Provider - 90% of negotiated rate. Non-PPO Provider - 70% of allowed charge.</p> <p>*Shingles Vaccine - covered.</p> | <p>Medicare-covered Part B vaccinations - No charge.</p> <p>*Shingles Vaccine - Not covered under Medical but covered under pharmacy.</p> | <p>Immunizations (including the vaccine) administered to you in a Plan Medical Office - No charge.</p> | |
| Substance Abuse Outpatient | <p>Subject to Deductible and \$15 copayment per visit. PPO Physician - 100% of negotiated rate. Non-PPO Physician - 70% allowed charge.</p> | <p>Inpatient detoxification - No charge. Individual outpatient substance use disorder evaluation and treatment - No charge. Group outpatient substance use disorder treatment - No charge.</p> | <p>Inpatient detoxification - No charge. Individual outpatient substance use disorder evaluation and treatment - \$10 per visit. Group outpatient substance use disorder treatment - \$5 per visit.</p> | |
| Mental Health Outpatient | <p>Subject to Deductible and \$15 copayment per visit. PPO Physician - 100% negotiated rate. Non-PPO Physician - 70% allowed charge.</p> | <p>Inpatient psychiatric hospitalization - No charge. Individual outpatient mental health evaluation and treatment - No charge. Group outpatient mental health treatment - No charge.</p> | <p>Inpatient psychiatric hospitalization - No charge. Individual outpatient mental health evaluation and treatment - \$10 per visit. Group outpatient mental health treatment - \$5 per visit.</p> | |
| Smoking Cessation | <p>Subject to Deductible and \$15 copayment per visit. PPO Physician - 100% negotiated rate. Non-PPO Physician - 70% allowed charge.</p> | <p>Medicare-covered smoking and tobacco use cessation preventive benefits - No charge.</p> | <p>Individual counseling during an office visit related to smoking cessation - No charge.</p> | |

| General Information | Labors 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 per 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 programs, which may include programs provided online and counseling over the phone - No charge. | |
| 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 equipment 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. | Hearing aid(s), including, fitting, counseling, adjustment, cleaning, and inspection - Not covered. Hearing exams with an audiologist to determine the need for hearing correction - \$10 per visit. | |

| Laborers Direct Payment Plan for Medicare and Non-Medicare Individuals | Anthem Blue Cross Medicare Advantage for Medicare Individuals | Kaiser Permanente for Non-Medicare Individuals | Kaiser Permanente Senior Advantage for Medicare Individuals |
|---|--|--|--|
| PRESCRIPTION DRUG BENEFITS | | | |
| <p>CarelonRx benefits provided through Fund whether you use a Contracting or Non-Contracting Pharmacy.</p> <p>CONTRACTING PHARMACY: You pay the copayment per prescription below.</p> <p>Retail 30 day supply maximum per prescription: Generic - \$10 * Formulary Brand Name - \$20. Non-Formulary Brand Name - \$30.</p> <p>Mail Order 90 day supply maximum per prescription: Generic - \$20 * Formulary Brand Name - \$40. Non-Formulary Brand Name - \$60.</p> <p>*If a generic equivalent is available but you prefer Brand Name, you will pay for the difference in cost between the generic and Brand Name drug.</p> <p>Maximum: \$50,000 maximum payable per individual, per calendar year for combined retail and mail order.</p> <p>Out-of-Pocket Maximum for Contracting Pharmacy only \$3,000 per person up to \$6,000 per family, per calendar year. Maximum does not apply to prescription drugs that are excluded by the Plan and penalties for non-compliance with the Plan's Utilization Review Program.</p> <p>NON-CONTRACTING PHARMACY: You pay the full cost and submit a Reimbursement Form to CarelonRx. You will be reimbursed based upon the contract rate for a Contracting Pharmacy less the applicable copayment and other costs described above. NO OUT-OF-POCKET MAXIMUM.</p> | <p>You pay the copayment per prescription below at Kaiser Permanente pharmacies; up to a 100-day supply of generic or medically necessary prescribed brand name drugs in accordance with Health Plan Formulary guidelines.</p> <p>Generic - \$5.</p> <p>Brand Name - \$15.</p> | <p>You pay the copayment per prescription below for covered drugs in accordance with Health Plan Formulary guidelines.</p> <p>Prescriptions written by non-Kaiser physicians are not covered.</p> <p>At a Kaiser Pharmacy Generic: \$5 for up to 30 day supply. \$10 for 31 - 60 day supply. \$15 for 61 - 100 day supply.</p> <p>Brand Name and specialty drugs: \$10 for up to 30 day supply. \$20 for 31 - 60 day supply. \$30 for 61 - 100 day supply.</p> <p>Mail Order Generic: \$5 for up to 30 day supply. \$10 for 31 - 100 day supply. Brand Name and specialty drugs: \$10 for up to 30 day supply. \$20 for 31 - 100 day supply.</p> | |

 **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

March 1, 2026

| Plan Features | Anthem Blue Cross Dental Complete | DeltaCare USA |
|---|--|--|
| Monthly Premium | \$85 regardless of family size | \$43 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**

March 1, 2026

| Anthem Blue Cross Blue View Vision (Monthly Premium: \$16) | | | |
|---|---------------------|---|---|
| Covered Benefit and Frequency Limitation | IN-NETWORK PROVIDER | | NON-NETWORK PROVIDER |
| | Plan Allowance | Your Copayment | |
| Routine Eye Exam <i>Every 12 months</i> | Covered in full | \$10 | \$37 allowance only |
| Eyeglass Frame <i>Every 12 months</i> | \$300 | You pay the balance after \$300 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 | \$10 (1 pair limit) | \$34 to \$68 allowance only depending on type of lenses |
| Contact Lenses (Conventional) <i>Every 12 months</i> | \$300 | You pay the balance after \$300 allowance less 15% discount | \$100 allowance only |

| Kaiser Vision Essentials (Monthly Premium: \$12) | | | |
|---|--------------------------------------|---|--|
| Covered Benefit and Frequency Limitation | AT KAISER PERMANENTE OPTICAL CENTERS | | |
| | Plan Allowance | Your Copayment | Notes |
| Routine Eye Exam <i>No limit</i> | Covered in full | \$10 | No copayment for preventive screenings |
| Eyeglass Frame <i>Every 24 months</i> | \$300 | You pay the balance after \$300 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> | \$300 | You pay the balance after \$300 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.