



Laborers Health and Welfare Trust Fund for Northern California
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Website: www.norcalaborers.org

TO: ALL RETIRED LABORERS AND THEIR ELIGIBLE DEPENDENTS COVERED UNDER THE RETIRED LABORERS PLAN EFFECTIVE MARCH 1, 2017

The Trust Fund offers Retired Participants and their eligible dependents a choice between two Medical-Hospital and Prescription Drug plans:

- Laborers Direct Payment Plan – a traditional fee-for-service plan
- Kaiser Permanente - a HHealth Maintenance Organization (HMO) plan

You and your eligible dependents may elect coverage under the Laborers Direct Payment Plan or Kaiser Permanente. Kaiser provides benefits at either no cost to you or with limited copayments; however, Kaiser limits your choice of physicians and facilities. The Laborers Direct Payment Plan provides traditional fee-for-service benefits and you may use any physician or hospital you wish, however, using an Anthem Blue Cross Prudent Buyer Plan provider may lower your out-of-pocket costs.

The enclosed Comparison and Summary of Benefits (see pages 3 to 6) is designed to help you choose a medical plan that suits your entire family's health care needs. We urge you to review the Comparison and the Retired Plan Rate Sheet (see page 2) *before* selecting a plan. You are allowed to change your plan no more than twice per calendar year.

Whether you select the Laborers Direct Payment Plan or a Kaiser Permanente, **you must complete a Laborers Retired Plan Application Form.** However, you must also complete a Kaiser Permanente Senior Advantage (KPSA) election form if you have Medicare and chosen KPSA. All forms that require completion must be mailed to the Trust Fund Office at the above address – **do not mail any of the forms directly to Kaiser Permanente.**

NOTIFY TRUST FUND OFFICE OF ANY CHANGE IN DEPENDENT STATUS

Whether you enroll in the Laborers Direct Payment Plan or Kaiser Permanente, you must notify the Trust Fund Office of any change in dependent status by completing a new Enrollment Form and submitting the required documents along with it. For example, if you want to add a dependent, such as a spouse, complete a new Enrollment Form and submit the appropriate document as requested on the form. If you want to delete a dependent, you must also submit a new Enrollment Form. If you fail to notify the Trust Fund Office of a change in dependent status, it may delay payment of claims. Enrollment Forms are available at your Local Union, the Trust Funds' web site or by calling the Trust Fund Office at the above telephone number.

If you need more information or have any questions concerning this insert, please do not hesitate to contact the Trust Fund Office. The staff will be happy to assist you.

Sincerely,

BOARD OF TRUSTEES

DECEMBER 21, 2016



LABORERS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
RETIRED PLAN RATE SHEET
MONTHLY SELF-PAYMENT RATES EFFECTIVE MARCH 1, 2017

Your monthly premium is 100% of the rate shown below for Medical-Hospital and Prescription Drug coverage unless you are entitled to a 25% or 50% subsidy based upon the following criteria: **(for more details about Retired Employee Subsidy, refer to Article II, Subsection 2.b. of the Rules and Regulations of your Retired Health and Welfare Plan)**

50% - 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 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% - You are age 55 or over and earned 10 - 24 Years of Credited Service.

The Trust Fund offers 3 dental plans: Delta Dental, DeltaCare USA and PrimeCare Dental (Union Dental) and 2 vision plans: Anthem Blue Cross Blue Vision and Kaiser Vision Essentials. If you elected dental and/or vision care coverage, your monthly premium is 100% of the rate shown below in addition to the monthly premium for Medical-Hospital and Prescription Drug coverage whether you elected the Laborers or Kaiser Permanente plan. The Retired Employee Subsidy does not apply to dental and vision coverage – you pay 100% of the monthly premium.

TYPE OF COVERAGE	MEDICAL-HOSPITAL & PRESCRIPTION DRUG PLAN			DENTAL PLAN	VISION PLAN
	LABORERS DIRECT PAYMENT PLAN	KAISER PERMANENTE (Non-Medicare)	KAISER PERMANENTE (Medicare)		
One Medicare	\$356		\$371	Regardless of family size, the monthly premium is the same.	Regardless of family size, the monthly premium is the same.
Two Medicare	\$699		\$741		
One Non-Medicare	\$814	\$1,030		Delta Dental - \$74	Anthem Vision - \$11
Two Non-Medicare	\$1,626	\$2,061			
One Medicare and One Non-Medicare	\$1,170	\$1,401	\$1,401	DeltaCare - \$50	*Kaiser Vision - \$5
One Medicare and Two Non-Medicare	\$1,170	\$2,256	\$2,256	PrimeCare (Union Dental) - \$65	* - if you are enrolled in the Laborers Direct Payment Plan, you are not allowed to choose Kaiser Vision.
Family (3 or more) If your family mix is different from above, call the Fund Office for the specific rates.	\$1,626 ALL Non-Medicare	\$2,916 ALL Non-Medicare	\$371 per person. Non-Medicare family members may enroll in Kaiser Non-Medicare Plan.		

Premium rates are subject to change every March 1.

RETIRED LABORERS HEALTH AND WELFARE PLAN - COMPARISON AND SUMMARY OF BENEFITS - EFFECTIVE MARCH 1, 2017

GENERAL INFORMATION	LABORERS Direct Payment Plan	Kaiser Permanente for Non-Medicare Individuals	Kaiser Permanente Senior Advantage for Medicare Individuals
When You Can Change Plans	You are free to change Medical-Hospital and Prescription Drug Plan twice in a calendar year. You and your dependents must be enrolled in the same Plan – that is, you may not enroll in the Direct Payment Plan and your dependents enroll in Kaiser Permanente. To change Plans, request a Retired Plan Application Form from the Fund Office, your Local Union or go to our website, www.norcalaborers.org , to print or order the form.		
Type of Plan	The Direct Payment Plan provides traditional, fee-for-service medical benefits and offers higher coverage when you use Anthem Blue Cross providers. For Medicare eligible individuals, the Plan will pay 100% of the Medicare eligible individual's Part A (Hospitalization) deductible and/or coinsurance; 100% of the Medicare eligible individual's responsibility under Part B provided the expenses are covered under 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.	You must reside within Kaiser Service Area.	
Choice of Physicians	Unlimited. Use of Anthem Blue Cross physicians result in lower out-of-pocket expenses.	Each member may use any Kaiser Permanente Physician.	
Specialized Care: In-Network	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.	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.	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.	
Claim Forms	None.	Required from non-Kaiser Permanente providers for emergency, out-of-area urgent care and post stabilization care.	
Annual Deductible	\$150 per individual, maximum of \$450 per family per Plan Year. Does not apply to Inpatient Hospital, Physical Exam and Prescription Drug benefits. Deductible amount applied in December, January and February will be carried forward to following Plan Year.	None.	

GENERAL INFORMATION	LABORERS Direct Payment Plan	Kaiser Permanente for Non-Medicare Individuals	Kaiser Permanente Senior Advantage for Medicare Individuals
Annual Benefit Maximum	\$750,000 per individual, \$2,000 reinstatement per Plan Year.	None. Some restrictions apply. \$1,500 maximum out-of-pocket per individual up to \$3,000 per family per year.	
Inpatient Hospital Medical/Surgery Mental Health	Not subject to Deductible. Anthem Blue Cross Hospital: 85% of 1st \$10,000 and 100% thereafter of negotiated rates. Non- Anthem Blue Cross Hospital: 65% of 1st \$10,000 and 100% thereafter of allowed charges. Exception: For emergencies and members residing outside California – 85%)	100% for all covered benefits and services at Kaiser Permanente medical facilities.	100% for all covered benefits and services at Kaiser Permanente medical facilities.
Total Hip or Knee Replacement Surgery	Same as Medical/Surgery above but not to exceed \$30,000 Maximum Plan Allowance.	Same as Medical/Surgery above.	Same as Medical/Surgery above.
Skilled Nursing Facility/ECF	Same as Medical/Surgery above.	100% for up to 100 days per benefit period when authorized by a Plan physician.	100% for up to 100 days per benefit period when authorized by a Plan physician.
Alcohol and Substance Abuse	Same as Medical/Surgery above.	100% for detoxification and rehabilitation services when authorized by a Plan physician.	100% for detoxification and rehabilitation services when authorized by a Plan physician.
Utilization Review	Automatic part of Plan procedures. Required for most hospital stay. Non-PPO elective admissions only - 20% penalty of first \$10,000 of allowed charges for non-compliance.	Automatic part of Plan procedures.	
Outpatient Hospital Care	Subject to Deductible. Anthem Blue Cross - 90% of negotiated rates. Non-Anthem Blue Cross – 90% of allowed charges.	\$10 copayment per visit for most outpatient services.	
Emergency Room Hospital	Subject to Deductible. Anthem Blue Cross - 90% of negotiated rate after a \$25 copayment. Non-Anthem Blue Cross - 90% of allowed charges after a \$50 copayment. Copayment waived under certain circumstances.	\$50 copayment per visit. Waived if admitted.	
Ambulatory Surgery Center	Subject to Deductible. Anthem Blue Cross - 90% of negotiated rates. Non-Anthem Blue Cross - \$500 max per day.	100% at a Kaiser Permanente medical facility, subject to a \$10 copayment.	
Home Health Care	90% of covered charges - only upon referral by Case Management.	100% when authorized by a Plan physician for part-time intermittent care.	
Hospice Care	90% of covered charges - only upon referral by Case Management.	100% when selected as alternative to traditional services and authorized by a Plan physician. For Non-Medicare members: Up to 100 visits per Accumulation Period.	

GENERAL INFORMATION	LABORERS Direct Payment Plan	Kaiser Permanente for Non-Medicare Individuals	Kaiser Permanente Senior Advantage for Medicare Individuals
Ambulance	Subject to Deductible. 75% of Allowed Charge*	100% per trip	
Physician Fees: Office Visits	Subject to Deductible. 75% of Allowed Charge*, less \$20 copayment per visit.	100% after \$10 copayment per visit.	100% after \$10 copayment per visit.
Electronic/On-line Medical Evaluation	Not subject to Deductible. You must use a physician through LiveHealth Online Service. 100% of allowed charge after \$10 copayment per visit.	N/A	N/A
Surgery	Subject to Deductible. 75% of Allowed Charge*	Inpatient - 100%. Outpatient - 100% after a \$10 copayment.	Inpatient - 100%. Outpatient - 100% after a \$10 copayment.
Physical Exam	Not subject to Deductible and Physician Office Visit copayment. Retirees and spouse: \$300 maximum per Plan Year; children older than 2 years old: \$200 maximum per Plan Year.	100% after a \$10 copayment.	100% after a \$10 copayment.
Emergency Room Physician	Subject to Deductible. 75% of Allowed Charge*	Inclusive with hospital charges – see Emergency Room Hospital.	Inclusive with hospital charges – see Emergency Room Hospital.
Immunizations Inoculations	Subject to Deductible. 75% of Allowed Charge*	100%.	
Outpatient Substance Abuse Treatment	Subject to Deductible. 75% of Allowed Charge*	Individual Therapy: 100% after \$10 copayment per visit. Group Therapy: 100% after \$5 copayment per visit.	
Mental Health Outpatient	Subject to Deductible. 75% of Allowed Charge*, less \$20 copayment per visit.	Individual Therapy: 100% after \$10 copayment per visit. Group Therapy: 100% after \$5 copayment per visit.	
Lab Test, X-Ray, MRI, CT Scan	Subject to Deductible. 75% of Allowed Charge*	100%.	
Chiropractic Benefits	Subject to Deductible. \$40 per visit up to 20 visits per Plan Year. X-rays limited to \$100 per Plan Year.	Not covered.	
Physical Therapy	Subject to Deductible. 75% of Allowed Charge*	100% after a \$10 copayment per visit.	
Durable Medical Equipment	Subject to Deductible. 75% of Allowed Charge*	100% when prescribed by a Plan physician and in accordance with Health Plan DME Formulary guidelines.	
Hearing Aids Device	Subject to Deductible. \$1,200 maximum per ear/device per 36 months.	No hardware appliances are covered. Only testing or exam is covered.	
Dental Care	Three optional dental benefits, Delta Dental, DeltaCare USA and PrimeCare Dental (Union Dental), are available for an additional monthly cost - see Comparison and Summary of the Dental Plans on page 7 for more information. You must pay for dental care coverage for a minimum of 6 months . You are allowed to change dental plans every March 1.		

GENERAL INFORMATION	LABORERS Direct Payment Plan	Kaiser Permanente for Non-Medicare Individuals	Kaiser Permanente Senior Advantage for Medicare Individuals
Vision Care	The Direct Payment Plan excludes vision care expenses such as eye exam, frames and lenses. For vision care coverage, you have an option to elect Anthem Blue Cross Blue View Vision for an additional monthly cost - see Comparison and Summary of the Vision Plans on page 8 for more information. You must pay for vision care coverage for a minimum of 6 months .	Kaiser's medical plan provides for an eye exam only at 100% after a \$10 copayment. For complete vision care coverage, you have an option to elect Anthem Blue Cross Blue View Vision or Kaiser Vision Essentials for an additional monthly cost - see Comparison and Summary of the Vision Plans on page 8 for more information. You must pay for vision care coverage for a minimum of 6 months and allowed to change plans every March 1.	Kaiser's <i>Senior Advantage</i> provides up to \$150 eyewear allowance every 24 months. For complete vision care coverage, you have an option to elect Anthem Blue Cross Blue View Vision or Kaiser Vision Essentials for an additional monthly cost - see Comparison and Summary of the Vision Plans on page 8 for more information. You must pay for vision care coverage for a minimum of 6 months and allowed to change plans every March 1.
Prescription Drugs	<p>OptumRx benefits provided through Fund.</p> <p><u>Retail</u> - You pay the copayment per prescription below. 30 day supply maximum per prescription: Generic - \$10 Formulary Brand Name - \$20 Non-Formulary Brand Name - \$30</p> <p><u>Mail Order</u> - You pay the copayment per prescription below. 90 day supply maximum per prescription: Generic - \$20 Formulary Brand Name - \$40 Non-Formulary Brand Name - \$60 Mail Order is mandatory for maintenance drugs after 3 fills.</p> <p><u>Maximum</u> - \$20,000 per individual, per calendar year combined retail and mail order.</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>You pay the copayment per prescription below at Kaiser Permanente pharmacies; 100 day supply of generic or medically necessary prescribed brand name drugs in accordance with Health Plan Formulary guidelines.</p> <p>Generic - \$5 Brand Name - \$15</p>	<p>You pay the copayment per prescription below for covered drugs in accordance with Health Plan Formulary guidelines.</p> <p><u>At a Kaiser Pharmacy</u> Generic: \$5 for up to 30 day supply. \$10 for 31 - 60 day supply. \$15 for 61 - 100 day supply. Brand Name: \$10 for up to 30 day supply. \$20 for 31 - 60 day supply. \$60 for 61 - 100 day supply.</p> <p><u>Mail Order</u> Generic: \$5 for up to 30 day supply. \$10 for 31 - 100 day supply. Brand: \$10 for up to 30 day supply. \$20 for 31 - 100 day supply.</p>
Toll-Free Numbers	1-800-244-4530	1-800-464-4000 (English) * 1-800-788-0616 (Spanish) Refer to Group Number 603307 when calling.	

***Allowed Charge – 75% of the negotiated rate for Anthem Blue Cross providers or 75% of allowed charge for non-Anthem Blue Cross providers.**
This Comparison and Summary of Benefits 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 or Kaiser Permanente's contract.



LABORERS HEALTH AND WELFARE TRUST FUND FOR RETIRED PLAN PARTICIPANTS COMPARISON AND SUMMARY OF THE DENTAL PLANS EFFECTIVE MARCH 1, 2017

Plan Features	Delta Dental of California		DeltaCare USA	PrimeCare (Union Dental)
	Premier	PPO		
Monthly Premium	\$74 regardless of family size	\$74 regardless of family size	\$50 regardless of family size	\$65 regardless of family size
Type of Plan	You may select any dentist, however, your out-of-pocket costs is greater if you use a non-Delta Dental Premier dentist.	PPO Plan. Dentists in the Delta Dental PPO Plan negotiate fees that are even lower than the Delta Dental Premier Plan.	Pre-paid HMO type Plan. You select a DeltaCare USA dentist who provides all services including referrals to Specialists.	Pre-paid HMO type Plan. You select a PrimeCare dentist who provides all services including referrals to Specialists.
Area Covered	Participating dentists within Northern California. Call 1-800-765-6003 for a list.	Participating dentists within Northern California. Call 1-800-765-6003 for a list.	Dental offices within Northern California. Call 1-800-422-4234 for locations.	Dental offices within Northern California. Call 1-866-998-3944 for locations.
Choice of Dentists	Any dentist, less out-of-pocket costs when you use a Delta Dental Premier dentist as fees are pre-negotiated and dentists cannot charge more than the pre-negotiated amount.	Any dentist, less out-of-pocket costs when you use a Delta Dental Premier dentist and even lower costs when you use a Delta Dental PPO dentist.	DeltaCare dentist only. All services and referrals must be provided by a DeltaCare dentist. No benefits will be paid if dental services are performed by other than a DeltaCare dentist.	PrimeCare dentist only. All services and referrals must be provided by a PrimeCare dentist. No benefits will be paid if dental services are performed by other than a PrimeCare dentist.
Annual Deductible	\$50/person, \$150/family. No Deductible for preventative and diagnostic services.	\$50/person, \$150/family. No Deductible for preventative and diagnostic services.	None	None
Annual Maximum	\$2,500 per person	\$2,500 per person	No maximum	No maximum
Out of Pocket Costs	Plan pays 100% for preventive & diagnostic services; 70% of usual, customary & reasonable (UC&R) for major services.	Plan pays 100% for preventive & diagnostic services; 70% of usual, customary & reasonable (UC&R) for major services.	Varying copayments	No copayments
Orthodontic Benefits	Not covered	Not covered	Member Copayments: Start-Up Fee: \$350 Treatment Adult: \$1,800 Treatment Child: \$1,600	Member Copayments: Start-Up Fee: Adult/\$200 Child/\$100 Treatment Adult: \$3,400 Treatment Child: \$1,350
Website	deltadentalins.com	deltadentalins.com	deltadentalins.com	primecaredental.net

THIS IS NOT A COMPREHENSIVE LISTING OF ALL COVERED DENTAL SERVICES AND OTHER LIMITATIONS AND EXCLUSIONS MAY APPLY.



**LABORERS HEALTH AND WELFARE TRUST FUND
FOR RETIRED PLAN PARTICIPANTS**

COMPARISON AND SUMMARY OF THE VISION PLANS EFFECTIVE MARCH 1, 2017

Direct Payment Plan Participants – Vision coverage is provided through Anthem Blue Cross Blue View Vision Plan. The Trust Fund **does not** offer other vision plans to Retired Participants who are enrolled in the Direct Payment Plan. If you want to change to Kaiser Vision Essentials Plan, you have to switch your Medical-Hospital and Prescription Drug Plan first to Kaiser Permanente.

Kaiser Permanente Plan Participants – Vision coverage is provided through Kaiser Vision Essentials Plan, however, Retired Participants who are enrolled in the Kaiser Permanente Plan are allowed to switch between Kaiser Vision Essentials Plan and Anthem Blue Cross Blue View Vision Plan every annual open enrollment period (December 1 - February 15 for a March 1 effective date).

**Anthem Blue Cross Blue View Vision
Premium Rate - \$11 per month (regardless of family size)**

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>	\$145	You pay the balance after \$145 allowance less 20% discount	\$40 allowance only
Eyeglass Standard Lenses <i>Every 12 months</i> 1 pair only of Single, Bifocal, Trifocal or Lenticular lenses	Covered in full	\$10 (1 pair limit)	\$34 to \$68 allowance only depending on type of lenses
Contact Lenses (Conventional) <i>Every 12 months</i>	\$120	You pay the balance after \$120 allowance less 15% discount	\$100 allowance only

**Kaiser Vision Essentials
Premium Rate - \$5 per month (regardless of family size)**

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>	\$145	You pay the balance after \$145 allowance	Fashionable frames priced between \$40 to \$99
Eyeglass Standard Lenses <i>Every 12 months</i>	Covered in full		1 pair only of clear plastic, single, flat-top multifocal or lenticular lenses
Contact Lenses (Conventional) <i>Every 12 months</i>	\$120	You pay the balance after \$120 allowance	Order refills online at kp2020.org/noca

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