LABORERS HEALTH AND WELFARE TRUST FUND FOR ACTIVE PLAN AND SPECIAL PLAN PARTICIPANTS
COMPARISON AND SUMMARY OF THE MEDICAL-HOSPITAL AND PRESCRIPTION DRUG PLANS
EFFECTIVE NOVEMBER 1, 2017

PLAN FEATURES	DIRECT PAYMENT PLAN	KAISER PERMANENTE
When Can You Change Your Medical-Hospital Plan?	New Participants are automatically enrolled in the Direct Payment Plan unless the Participant opted for Kaiser Permanente prior to initial eligibility. ALL Participants are allowed to change their Medical-Hospital and Prescription Drug Plans 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 to another Plan, request an Active Plan & Special Plan Application Form from the Trust Fund Office, your Local Union or go to our website, www.norcalaborers.org, to print or order the form.	
Type of Plan	The Plan provides traditional, fee-for-service medical benefits and offers higher coverage when you use Anthem Blue Cross providers.	Care is provided through physicians or medical staff at a Kaiser Permanente facility located in the member's service area.
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 may enroll in Kaiser Permanente if you live or work within Kaiser Service Area.
Choice of Physicians	Unlimited. Use of Anthem Blue Cross physicians result in lower out-of-pocket expenses.	Members must use a Kaiser Permanente Physician.
Specialized Care In-Network Specialized Care Outside 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. An outside specialist requires specific referral from your Plan Physician. Cost Sharing is consistent with Plan coverages 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 condition.	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.
Claim Forms	None.	Required for emergency care, post-stabilization care, and out-of-area urgent care from non-Kaiser Permanente providers.
Annual Deductible	$150/individual, $450/family per Plan Year (3/1 – 2/28). Does not apply to Inpatient Hospital, Physical Exam and Prescription Drug benefits. Deductible amount applied in December, January and February (12/1 – 2/28) will be carried forward to following Plan Year.	$150/individual, $450/family per Calendar Year (1/1 – 12/31). Deductible amount applied in October, November and December (10/1 – 12/31) will be carried forward to following Calendar Year.
Annual Benefit Limit	None, some restrictions apply for Chiropractic Care and Hearing Aids.	None. Some restrictions apply.
Annual Out-of-Pocket Expense Maximum	$3,000/individual, $6,000/family per Plan Year. Includes your deductible, coinsurance and copayment for hospital stay for charges by PPO providers only. Does not include Physician Visit or Emergency Room copayment, charges over Maximum Plan Allowance, penalties for not using a PPO hospital or not obtaining a pre-admission review for admission to a non-participating hospital, coinsurance for charges by non-PPO providers, Plan exclusions and limitations.	$3,000/individual, $6,000/family per Calendar Year.

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Inpatient Hospital Medical/Surgery Mental Health	Not subject to Deductible. PPO Hospital - 90% of the first $10,000 of negotiated rates, 100% thereafter for medically necessary hospital services. Non-PPO Hospital - 70% (10% regular copayment plus 20% penalty for not using a PPO) of first $10,000 of allowed charges, 100% thereafter. (Exception: Emergency admission and participants residing outside the service area - payable at 90% instead of 70%)	Subject to deductible. 90% payable for all covered benefits and services at Kaiser Permanente medical facilities.
Skilled Nursing Facility	Same as Medical/Surgery above.	90% payable after deductible up to 100 days per benefit period.
Alcohol and Substance Abuse	Same as Medical/Surgery above.	90% Inpatient Detoxification after deductible for services at Kaiser Permanente medical facilities.
Routine Total Hip or Knee Replacement Procedure	Same as Medical/Surgery above but subject to $30,000 Maximum Plan Allowance. Higher out-of-pocket costs if you do not use a **Value-Based Site** hospital approved by the Plan.	Same as Medical/Surgery above.
Utilization Review	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. PPO Hospital - 90% of negotiated rates. Non-PPO Hospital – 70% of allowed charges.	Subject to Deductible. 90% payable for most outpatient services.
Emergency Room Hospital	Subject to Deductible. PPO Hospital - 90% of negotiated rate after $25 copayment. Non-PPO Hospital - 70% of allowed charges after $50 copayment. Copayment waived under certain circumstances.	Subject to Deductible. 90% payable. Waived if admitted.
Ambulatory Surgery Center	Subject to Deductible. Anthem Blue Cross Facility - 90% of negotiated rate. Non-Anthem Blue Cross Facility - $500 maximum payable per day.	Subject to Deductible. 90% payable.
Outpatient Hospital (Facility Charges) for Arthroscopic, Cataract, Colonoscopy	Subject to deductible. PPO Hospital - 90% of negotiated rates and subject to Maximum Plan Allowance (MPA) below. Exception: MPA does not apply if a **Value-Based Site surgery center is used.** Non-PPO Hospital – 70% of allowed charges and subject to MPA Arthroscopy $6,000 * Cataract $2,000 * Colonoscopy $1,500	Subject to Deductible. 90% payable.
Home Health Care	Subject to Deductible. 90% of negotiated rate. Must be pre-authorized by Anthem Blue Cross of California.	100% payable up to 100 visits per Calendar Year when authorized by Plan physician for part-time, intermittent care.
Hospice Care	Subject to Deductible. 90% of negotiated rate. Must be pre-authorized by Anthem Blue Cross of California.	100% payable when selected as alternative to traditional services and authorized by a Plan physician.
Physician Office Visit	Subject to Deductible. PPO - 100% negotiated rate after $15 copayment per visit. Non-PPO - 70% allowed charge after $15 copayment per visit.	Subject to Deductible. $15 copayment per visit.

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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.	Not subject to deductible, 100% payable. Provided under certain circumstances to be determined during telephonic appointment intake.
Surgery Physician Fee	Subject to Deductible. PPO Physician - 90% of negotiated rate. Non-PPO Physician - 70% of allowed charge.	Subject to Deductible. 90% payable.
Physician Fee For Emergency Room Visit	Subject to Deductible. PPO Physician - 90% of negotiated rate. Non-PPO Physician: 90% of allowed charge if a PPO hospital is used. 70% of allowed charge if a Non-PPO hospital is used.	Subject to Deductible. (Waived if admitted). 90% payable.
Physical Exam/ Well Baby	Not subject to Deductible, no Office Visit copayment. Participant or Spouse - $300 maximum per exam. Child older than age 2 - $200 maximum 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.	Not subject to Deductible. Adult - $0 copayment per visit. Children through age 23 months - $0 copayment per visit.
Diagnostic Lab Tests, X-Ray, MRI, CT Scan	Subject to Deductible. PPO Facility - 90% of negotiated rate. Non-PPO Facility - 70% of allowed charge.	Subject to Deductible. $10 copayment per encounter for most x-rays & lab. MRI, CT Scan and PET Scan - $50 copayment.
Immunizations and Inoculations (Shots)	Subject to Deductible. PPO Provider - 90% of negotiated rate. Non-PPO Provider - 70% of allowed charge.	100% payable.
Outpatient Mental Health Visits	Subject to Deductible. PPO Physician - 100% negotiated rate after $15 copayment per visit. Non-PPO Physician - 70% allowed charge after $15 copayment per visit.	Subject to Deductible. Individual Therapy: 100% after $15 copayment per visit. Group Therapy: 100% after $7 copayment per visit.
Outpatient Alcohol and Substance Abuse Treatment	Subject to Deductible. PPO provider - 90% of negotiated rate. Non- PPO Provider - 70% of allowed charge.	Subject to Deductible. Individual Therapy: 100% after $15 copayment per visit. Group Therapy: 100% after $5 copayment per visit.
Chiropractic Care	Subject to Deductible. $40 per visit up to 20 visits per Plan Year. X-rays limited to $100 per Plan Year.	Not subject to Deductible. $5 copayment per visit, 20 visits maximum per Calendar Year. $50 maximum allowance for appliance.
Physical Therapy Occupational Therapy	Subject to Deductible. PPO Provider - 90% of negotiated rate. Non-PPO Provider - 70% of allowed charge.	Subject to Deductible. $15 copayment per visit.
Ambulance	Subject to Deductible. **** - if due to a life threatening condition.** Air ambulance covered******. PPO Provider - 90% of negotiated rate. Non-PPO Provider - 70% of allowed charge (or 90%******)	Subject to Deductible. Emergency: 90% payable per trip when medically necessary. Non-Emergency: 90% payable per trip when medically necessary and authorized by a Kaiser Permanente Physician.
Hearing Aids/Device	Subject to Deductible. $1,200 maximum allowance per ear/device every 36 months.	Not subject to Deductible. $1,000 maximum allowance per ear/device every 36 months.

PLAN FEATURES	DIRECT PAYMENT PLAN	KAISER PERMANENTE
Durable Medical Equipment	Subject to Deductible. Must be prescribed by a physician. PPO Provider - 90% of negotiated rate. Non-PPO Provider - 70% of allowed charge.	Not subject to Deductible. 90% payable when prescribed by a Plan physician and in accordance with Health Plan DME formulary guidelines.
Prescription Drugs	OptumRx benefits provided through Fund. Retail – You pay the copayment below per prescription. 30 day supply maximum per prescription. Generic - $10 Formulary Brand Name - $20 * Non-Formulary Brand Name - $30 Mail Order - You pay the copayment below per prescription. 90 day supply maximum per prescription. Generic - $20 Formulary Brand Name - $40 * Non-Formulary Brand Name - $60 Mail Order is mandatory for maintenance drugs. 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.	At a Kaiser Pharmacy - You pay the copayment below per prescription. 30 day supply maximum for certain drugs. Generic: $10 for up to 30 day supply. $20 for up to 100 day supply. Brand Name: $20 for up to 30 day supply. $40 for up to 100 day supply. Mail Order - You pay the copayment below per prescription. 100 day supply maximum per prescription. Generic - $20 Brand - $40 Prescriptions written by non-Kaiser physicians are not covered.
Death Benefits	All Participants are eligible for the following death benefits whether enrolled in the Direct Payment or Kaiser Permanente: Participant: Regular Death $15,000 * Accidental Death $15,000 * Dismemberment - $7,500 to $15,000 Dependents: Spouse Death $7,500 * Child Death: $1,000 regardless of age	
Toll-Free Numbers	**1-800-244-4530**	**1-800-390-3507 (English) or 1-800-788-0616** (Spanish). Refer to Group #: 603306 for Active Plan, 603308 for Special Plan
Vision Plans	Participants enrolled in the Direct Payment Plan are automatically enrolled in Anthem Blue Cross **"Blue View Vision".** The Trust Fund Office does not offer other vision plans. For more information, refer to the attached Comparison and Summary of the Vision Plans.	Participants enrolled in the Kaiser Permanente Plan are automatically enrolled in Kaiser **"Vision Essentials"** Plan but have an option to enroll in Anthem Blue Cross **"Blue View Vision"** during open enrollment (March 1 effective date). For more information, refer to the attached Comparison and Summary of the Vision Plans.
Dental Plans	New Participants are automatically enrolled in Anthem Blue Cross Dental Complete Plan but have an option to elect another dental plan offered by the Trust Fund Office within 60 days from initial eligibility. All Participants are allowed to switch dental plans every open enrollment period (December 1 – February 28) for an effective date of March 1 – for more information, refer to the attached Comparison and Summary of the Dental Plans.	

This comparison and summary chart 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 each to plan. The contents of this comparison are not to be construed or accepted as a substitute for the provisions of the Laborers Health and Welfare Active or Special Plan's Rules and Regulations or Kaiser Permanente's contract.

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LABORERS HEALTH AND WELFARE TRUST FUND FOR ACTIVE AND SPECIAL PLANS PARTICIPANTS
COMPARISON AND SUMMARY OF THE DENTAL PLANS EFFECTIVE NOVEMBER 1, 2017

Plan Features	Anthem Blue Cross (ABC) Dental Complete	Bright Now!	PrimeCare (Union Dental)	United HealthCare	DeltaCare USA
Type of Plan	Traditional Dental Plan.	Pre-paid HMO Dental Plan.	Pre-paid HMO Dental Plan.	Pre-paid HMO Dental Plan.	Pre-paid HMO Dental Plan.
Choice of Dentists	You may select any dentist. Your out-of-pocket costs is greater if you use a non-ABC dentist. Emergency dental care outside USA are covered under International Emergency Dental Program.	All services and referrals must be provided by a Bright Now! or contracted dentist. No Non-emergency benefits will be paid if dental services are performed by other than a Bright Now! or contracted dentist.	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.	All services and referrals must be provided by a contracted UHC dentist. No benefits will be paid if dental services are performed by other than a contracted UHC dentist.	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.
Area Covered	Any dentist within USA. ABC dentists located within California. Outside California, dentists participate in Anthem Blue Cross Blue Shield dental network.	21 Dental offices within Northern California .	Dental offices within Northern California.	Dental offices within Northern California.	Dental offices within Northern California.
Annual Deductible	$100 per person, $300 per family. Preventative and diagnostic services are NOT subject to the Deductible.	None	None	None	None
Annual Maximum	$2,500 per person	General care: No maximum Specialty Referrals: $2,500	No maximum	No maximum	No maximum
Participant Coinsurance Copayment	0% for preventive & diagnostic services; 30% for major services.	No copayments on covered procedures.	No copayments	Minimal copayments	Varying copayments
Orthodontic Benefits	50% member coinsurance. $1,500 lifetime maximum for member, spouse or child.	Member Copayments: Start-Up Fee: $540 Treatment Adult: $2,800 Treatment Child: $2,400	Member Copayments: Start-Up Fee Adult: $200 Start-Up Fee Child: $100 Treatment Adult: $3,400 Treatment Child: $1,350	Member Copayments: Treatment Adult: $1,250* Treatment Child: $1,250* *including Start-Up Fee	Member Copayments: Start-Up Fee: $350 Treatment Adult: $1,800 Treatment Child: $1,600
Phone No. & Website	1-877-567-1804 anthem.com/ca/mydental	1-888-274-4486 brightnow.com	1-866-998-3944 primecaredental.net	1-800-999-3367 myuhc.com	1-800-422-4234 deltadentalins.com

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 ACTIVE AND SPECIAL PLANS PARTICIPANTS
COMPARISON AND SUMMARY OF THE VISION PLANS
EFFECTIVE NOVEMBER 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 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, 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 Summary of Benefit

Covered Benefit and Frequency Limitation	IN-NETWORK PROVIDER		NON-NETWORK PROVIDER
	Plan Allowance	Your Copayment	
Routine Eye Exam *Every 12 months*	Covered in full	$10	$37 allowance only
Eyeglass Frame *Every 24 months*	$145	You pay the balance after $145 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	$20 (1 pair limit)	$34 to $68 allowance only depending on type of lenses
Contact Lenses (Conventional) *Every 12 months*	$120	You pay the balance after $120 allowance less 15% discount	$100 allowance only

Kaiser Vision Essentials Summary of Benefit

Covered Benefit and Frequency Limitation	AT KAISER PERMANENTE OPTICAL CENTERS		
	Plan Allowance	Your Copayment	Notes
Routine Eye Exam *No limit*	Covered in full	$15	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*	Covered in full		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 kp2020.org/noca

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