**Laborers Health and Welfare Trust Fund for Northern California**
**220 Campus Lane * Fairfield, California 94534-1498**
**Telephone: (707) 864-2800 Toll-Free: (800) 244-4530**
**Website: www.norcalaborers.org**

**TO: ALL RETIRED LABORERS AND THEIR ELIGIBLE DEPENDENTS COVERED UNDER THE RETIRED LABORERS PLAN EFFECTIVE NOVEMBER 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 **H**ealth **M**aintenance **O**rganization (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***. You must also complete a **K**aiser **P**ermanente **S**enior **A**dvantage (**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 your dependent spouse or child(ren), complete a new Enrollment Form and submit the required proof of relationship document as listed on the Enrollment 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

AUGUST 11, 2017

# LABORERS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA

RETIRED PLAN RATE SHEET

MONTHLY SELF-PAYMENT RATES EFFECTIVE NOVEMBER 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: Anthem Blue Cross Dental Complete, DeltaCare USA and PrimeCare Dental (Union Dental) and 2 vision plans: Anthem Blue Cross Blue View 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 Direct Payment 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.<br><br>Anthem Blue Cross - $74<br><br>DeltaCare USA - $50<br><br>PrimeCare Dental (Union Dental) - $65 | Regardless of family size, the monthly premium is the same.<br><br>Anthem Vision - $11<br><br>*****Kaiser Vision - $5<br><br>*** - if you are enrolled in the Laborers Direct Payment Plan, you are not allowed to choose Kaiser Vision.** |
| Two Medicare | $699 | | $741 | | |
| One Non-Medicare | $814 | $1,030 | | | |
| Two Non-Medicare | $1,626 | $2,061 | | | |
| One Medicare and One Non-Medicare | $1,170 | $1,401 | $1,401 | | |
| One Medicare and Two Non-Medicare | $1,170 | $2,256 | $2,256 | | |
| Family (3 or more)<br>**If your family mix is different from above, call the Fund Office for the specific rates.** | $1,626<br>ALL Non-Medicare | $2,916<br>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 NOVEMBER 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<br><br>Outside Network | You select any specialist.<br><br>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.<br><br>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.<br><br>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 |
|---|---|---|---|
| Lifetime 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**<br>Medical/Surgery<br>Mental Health | Not subject to Deductible.<br>Anthem Blue Cross Hospital: 85% of 1st $10,000 and 100% thereafter of negotiated rates.<br>Non- Anthem Blue Cross Hospital: 65% of 1st $10,000 and 100% thereafter of allowed charges.<br>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.<br>Anthem Blue Cross - 90% of negotiated rates.<br>Non-Anthem Blue Cross – 90% of allowed charges. | $10 copayment per visit for most outpatient services. | |
| Emergency Room Hospital | Subject to Deductible.<br>Anthem Blue Cross - 90% of negotiated rate after a $25 copayment.<br>Non-Anthem Blue Cross - 90% of allowed charges after a $50 copayment.<br>Copayment waived under certain circumstances. | $50 copayment per visit.<br>Waived if admitted. | |
| Ambulatory Surgery Center | Subject to Deductible.<br>Anthem Blue Cross - 90% of negotiated rates.<br>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.<br>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.<br>75% of Allowed Charge* | Inpatient - 100%.<br>Outpatient - 100% after a $10 copayment. | Inpatient - 100%.<br>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.<br>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.<br>75% of Allowed Charge* | 100%. | |
| Outpatient Substance Abuse Treatment | Subject to Deductible.<br>75% of Allowed Charge* | Individual Therapy: 100% after $10 copayment per visit.<br>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.<br>Group Therapy: 100% after $5 copayment per visit. | |
| Lab Test, X-Ray, MRI, CT Scan | Subject to Deductible.<br>75% of Allowed Charge* | 100%. | |
| Chiropractic Benefits | Subject to Deductible.<br>$40 per visit up to 20 visits per Plan Year.<br>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.<br>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.<br>$1,200 maximum per ear/device per 36 months. | No hardware appliances are covered.<br>Only testing or exam is covered. | |
| Dental Care | Three optional dental benefits, Anthem Blue Cross Dental Complete, 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.<br>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 *Senior Advantage* 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 | OptumRx benefits provided through Fund.<br><br>Retail - You pay the copayment per prescription below. 30 day supply maximum per prescription:<br>Generic - $10<br>Formulary Brand Name - $20<br>Non-Formulary Brand Name - $30<br><br>Mail Order - You pay the copayment per prescription below. 90 day supply maximum per prescription:<br>Generic - $20<br>Formulary Brand Name - $40<br>Non-Formulary Brand Name - $60<br>Mail Order is mandatory for maintenance drugs after 3 fills.<br><br>Maximum - $20,000 per individual, per calendar year combined retail and mail order.<br><br>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. | 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.<br><br>Generic - $5<br>Brand Name - $15 | You pay the copayment per prescription below for covered drugs in accordance with Health Plan Formulary guidelines.<br><br>At a Kaiser Pharmacy<br>Generic:<br>$5 for up to 30 day supply.<br>$10 for 31 - 60 day supply.<br>$15 for 61 - 100 day supply.<br>Brand Name:<br>$10 for up to 30 day supply.<br>$20 for 31 - 60 day supply.<br>$60 for 61 - 100 day supply.<br><br>Mail Order<br>Generic:<br>$5 for up to 30 day supply.<br>$10 for 31 - 100 day supply.<br>Brand:<br>$10 for up to 30 day supply.<br>$20 for 31 - 100 day supply. |
| Toll-Free Numbers | 1-800-244-4530 | 1-800-464-4000 (English) * 1-800-788-0616 (Spanish)<br>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 NOVEMBER 1, 2017

| Plan Features | Anthem Blue Cross (ABC) Dental Complete | PrimeCare (Union Dental) | DeltaCare USA |
|---|---|---|---|
| ***Monthly Premium*** | $74 regardless of family size | $65 regardless of family size | $50 regardless of family size |
| ***Type of Plan*** | Traditional Fee-for-Service 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 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 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. | Dental offices within Northern California. | Dental offices within Northern California. |
| ***Annual Deductible*** | $50 per person, $150 per family. Preventative and diagnostic services are NOT subject to the Deductible. | None | None |
| ***Annual Maximum*** | $2,500 per person | No maximum | No maximum |
| ***Participant Coinsurance Copayment*** | 0% for preventive & diagnostic services; 30% for major services. | No copayments | Varying copayments |
| ***Orthodontic Benefits*** | Not covered | Member Copayments:<br>Start-Up Fee Adult: $200<br>Start-Up Fee Child: $100<br>Treatment Adult: $3,400<br>Treatment Child: $1,350 | Member Copayments:<br>Start-Up Fee: $350<br>Treatment Adult: $1,800<br>Treatment Child: $1,600 |
| ***Phone No. & Website*** | 1-877-567-1804<br>anthem.com/ca/mydentalvision | 1-866-998-3944<br>primecaredental.net | 1-800-422-4234<br>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 RETIRED PLAN 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 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<br>*Every 12 months* | Covered in full | $10 | $37 allowance only |
| Eyeglass Frame<br>*Every 12 months* | $145 | You pay the balance after $145 allowance less 20% discount | $40 allowance only |
| Eyeglass Standard Lenses<br>*Every 12 months*<br><br>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)<br>*Every 12 months* | $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<br>*No limit* | Covered in full | $10 | No copayment for preventive screenings |
| Eyeglass Frame<br>*Every 24 months* | $145 | You pay the balance after $145 allowance | Fashionable frames priced between $40 to $99 |
| Eyeglass Standard Lenses<br>*Every 12 months* | Covered in full | | 1 pair only of clear plastic, single, flat-top multifocal or lenticular lenses |
| Contact Lenses (Conventional)<br>*Every 12 months* | $120 | You pay the balance after $120 allowance | Order refills online at kp2020.org/noca |

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