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

TO: ALL RETIRED LABORERS AND THEIR ELIGIBLE DEPENDENTS COVERED UNDER THE RETIRED LABORERS PLAN

CHOICE OF MEDICAL PLANS

The Trust Fund offers Retired Laborers and their eligible dependents a choice of health plans. You and your eligible dependents may elect coverage under the Retired Laborers *Managed Care* Plan or one of three health maintenance organizations (HMO's) available through the Fund. Your choice of medical plans are as follows:

- Retired Laborers *Managed Care* Plan
- Health Net
- Kaiser Foundation Health Plan
- PacifiCare

An HMO provides benefits at either no cost to you or with limited co-payments; however, it limits your choice of physicians. The Fund's *Managed Care* Plan provides traditional fee-for-service benefits. Under the Laborers *Managed Care* Plan, you may use any physician or hospital you wish, however, use of a Prudent Buyer Plan provider may lower your out-of-pocket costs.

The Comparison of Benefits Plans 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 accompanying Rate Sheet *before* selecting a plan. **You should be aware that you are allowed to change to any medical plan no more than twice every calendar year.**

Once you have selected a plan, complete a *Plan Benefit Application Form* and mail it to the Fund Office at the above address. IMPORTANT: IF YOU WISH TO ENROLL IN A "MEDICARE RISK" PROGRAM, YOU MUST COMPLETE A PLAN BENEFIT APPLICATION FORM AND THE HMO'S RETIRED PLAN BENEFIT APPLICATION FORM. AN HMO APPLICATION MUST BE COMPLETED FOR EACH INDIVIDUAL WISHING TO ENROLL IN A "MEDICARE RISK" PROGRAM.

NOTIFY FUND OFFICE OF ANY CHANGE IN DEPENDENT STATUS

Whether you enroll in one of the HMO's or the Fund's *Managed Care* Plan, you must notify the Fund Office of any change in dependent status by completing an 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 reverse side of the card. If you want to delete a dependent, you must also submit a new Enrollment Form. If you fail to notify the Fund Office of a change in dependent status, it may delay payment of claims.

Enrollment Forms are available through your Local Union or by calling the 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 Fund Office. The staff will be happy to assist you.

Sincerely,

BOARD OF TRUSTEES

SEPTEMBER 1, 2003

GENERAL INFORMATION	LABORERS MANAGED HEALTH CARE PLAN	HEALTH NET ("Regular Retiree" Program)	HEALTH NET *SENIORITY PLUS* ("Medicare-Risk" Program)	KAISER (Non-Medicare Eligible)	KAISER *SENIOR ADVANTAGE* (Medicare Eligible)	PACIFICARE (Non-Medicare Eligible)	PACIFICARE *SECURE HORIZONS* ("Medicare-Risk" Program)
Type of Plan	The Fund's Managed Health Care Plan provides traditional, fee-for-service medical benefits. You may seek care from any hospital or physician you like. Managed Care offers benefits at lower costs when you use *Prudent Buyer Plan* hospitals, physicians, laboratory, radiology and ambulatory surgical facilities. **Plan benefits are reduced by Medicare payments for Medicare eligible participants.**	HMO provides all care through a network of contract hospitals, doctors and medical centers. A Primary Care Physician coordinates all medical care needs. Medicare-eligible retirees can still receive Medicare benefits outside the Health Net program.	HMO provides all care through a network of contract hospitals, doctors and medical centers. A Primary Care Physician coordinates all medical care needs. All care must be provided through Health Net. **MEDICARE WILL NOT PAY FOR OR PROVIDE BENEFITS FOR SERVICES RECEIVED OUTSIDE THE HEALTH NET SENIORITY PLUS PROGRAM.**	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 PERMANENTE SENIOR ADVANTAGE PROGRAM.**	HMO provides all care through a network of contract hospitals, doctors and medical centers. A Primary Care Physician coordinates all medical care needs.	HMO provides all care through a network of contract hospitals, doctors and medical centers. A Primary Care Physician coordinates all medical care needs. **MEDICARE WILL NOT PAY FOR OR PROVIDE BENEFITS FOR SERVICES RECEIVED OUTSIDE THE PACIFICARE *SECURE HORIZONS* PROGRAM.**
Geographical Area Covered	United States, its territories and possessions. Services outside United States may be covered if due to emergency.	See enclosed letter which advises if this plan is available to you.	See enclosed letter which advises if this plan is available to you.	See enclosed letter which advises if this plan is available to you.	See enclosed letter which advises if this plan is available to you.	See enclosed letter which advises if this plan is available to you.	See enclosed letter which advises if this plan is available to you.
Choice of Physicians	Unlimited. Use of a *Prudent Buyer Plan* physician may result in lower out-of-pocket expenses.	Each member selects a Participating Medical Group (PMG) within 30 miles of his or her residence; each member then selects a Primary Care Physician from the PMG.	Each member selects a Participating Medical Group (PMG) within 30 miles of his or her residence; each member then selects a Primary Care Physician from the PMG.	Each member may use any Kaiser Permanente Physician.	Each member may use any Kaiser Permanente Physician.	Each member selects a Primary Care Physician within 30 miles of his or her residence.	Each member selects a Primary Care Physician within his or her zip code.
Specialized Care: In-Network	You may select any specialist.	Your Primary Care Physician refers you to a Health Net specialist.	Your Primary Care Physician refers you to a Health Net specialist.	Self-referral to specialties such as allergy, dermatology, psychiatry.	Your Kaiser Physician refers you to other specialists.	Your Primary Care Physician refers you to a PacifiCare specialist.	Your Primary Care Physician refers you to a *Secure Horizons* specialist.
Outside Network	You may select any specialist.	Covered in full if authorized by your Participating Medical Group.	Covered in full if authorized by your Participating Medical Group.	Covered in full if Kaiser Physician refers you to outside specialists.	Covered in full if Kaiser Physician refers you to outside specialists.	Covered in full if PacifiCare refers you.	Covered in full if *Secure Horizons* refers you.
Out-of-Area Care	Out of network benefits apply to treatment anywhere in the United States, its territories and possessions.	Emergency services only. 100% after $35 co-payment. Waived if admitted.	Emergency services only. 100% after $20 co-payment. Waived if admitted.	100% worldwide emergency coverage for unforeseen illness or injury after a $5 co-payment (waived if admitted).	100% worldwide emergency coverage for unforeseen illness or injury after a $5 co-payment. Waived if admitted.	Emergency services only. 100% after $35 co-payment. Waived if admitted.	Emergency services only. 100% after $20 co-payment. Waived if admitted.
Claim Forms	No claim forms when you use a *Prudent Buyer Plan* provider.	No claim forms except for out-of-area emergency services.	No claim forms except for out-of-area emergency services.	No claim forms except for out-of-plan emergency care.	No claim forms except for out-of-plan emergency care.	No claim forms except for out-of-area care.	No claim forms except for out-of-area care.
INPATIENT HOSPITAL BENEFITS							
Medical/Surgical	*Prudent Buyer Plan*: 85% of 1st $10,000 and 100% thereafter of negotiated rates for medically necessary hospital services during first 30 days of confinement per period of disability. Non-*Prudent Buyer Plan:* 65% of 1st $10,000 of covered charges; 100% thereafter during first 20 days of confinement. (Exception: For emergencies and participants residing outside service area,[1] benefits are payable at 85%, not 65%.)	100%.	100%.	100% for all covered benefits and services at Kaiser Permanente medical facilities.	100% for all covered benefits and services at Kaiser Permanente medical facilities.	100%.	100%.
Extended Care Facility/ Skilled Nursing Facility	85% of first $10,000 and 100% thereafter of covered charges for 30 days. Covered charges include 100% of lowest semi-private room and ICU rate or 80% of lowest private room rate; 100% of miscellaneous charges. Each two days of confinement in an extended care facility counts as one day in determining a combined hospital and extended care facility day limit.	100% for up to 100 days per calendar year.	100% for up to 100 days **per benefit period**.	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.	100% for up to 100 days per calendar year.	100% for up to 100 days per **benefit period**, as long as determined medically necessary by your Primary Care Physician.
Utilization Review	Automatic part of Plan procedures when admitted to *Prudent Buyer Plan* hospital. Required for **ALL** hospital admissions. Penalty of 20% reduction of first $10,000 of covered expenses for non-compliance.	Automatic part of Plan procedures.	Automatic part of Plan procedures.	Automatic part of Plan procedures.	Automatic part of Plan procedures.	Automatic part of Plan procedures.	Automatic part of Plan procedures.

GENERAL INFORMATION	LABORERS MANAGED HEALTH CARE PLAN	HEALTH NET ("Regular Retiree" Program)	HEALTH NET *SENIORITY PLUS* ("Medicare-Risk" Program)	KAISER (Non-Medicare Eligible)	KAISER *SENIOR ADVANTAGE* (Medicare Eligible)	PACIFICARE (Non-Medicare Eligible)	PACIFICARE *SECURE HORIZONS* ("Medicare-Risk" Program)
Mental Health	Regular plan benefits payable. (See Medical/Surgical benefits.)	NOT COVERED.	100% up to **190 days lifetime maximum** in Medicare-contracting hospital.	100% up to **45 days per calendar year.**	100% up to **45 days per calendar year, plus 190 days per lifetime.**	NOT COVERED.	100% up to **190 days lifetime maximum**.
Alcohol/Substance Abuse	Not covered.	100% for detoxification only. Rehabilitation is not covered.	100%.	100% for detoxification only. Rehabilitation is not covered.	100% for detoxification only (rehabilitation is not covered).	100%.	100% for detoxification only. Rehabilitation is not covered.
OUTPATIENT / COMPREHENSIVE MEDICAL BENEFITS							
Deductible	$150 per person up to $450 per family per Plan Year. Not applicable to Inpatient Hospital, Extended Care Facility, Prescription Drug benefits or individuals eligible under Medicare.	None.	None.	None.	None.	None.	None.
Plan Maximum	$500,000 lifetime per person with a $2,000 Plan Year reinstatement. Lifetime maximum does not apply to Inpatient Hospital, Extended Care facility or Prescription Drug benefits.	None. Some restrictions apply.	None. Some restrictions apply.	None. Some restrictions apply.	None. Some restrictions apply.	None. Some restrictions apply.	None. Some restrictions apply.
Outpatient Hospital	*Prudent Buyer Plan* - 90% of negotiated rates. Non-*Prudent Buyer Plan* - see footnote #2.			$5 co-payment per visit for most outpatient services.	$5 co-payment per visit for most outpatient services.		
Hospital Emergency Room	*Prudent Buyer Plan* - 90% of negotiated rate less a $25 co-payment. Non-*Prudent Buyer Plan* - 90% of covered charges less a $50 co-payment. Co-payment waived under certain circumstances.	100% after $35 co-payment. Waived if admitted.	100% after $20 co-payment. Waived if admitted.	$5 co-payment per visit. Waived if admitted.	$5 co-payment per visit. Waived if admitted.	$35 co-payment. Waived if admitted.	$20 co-payment. Waived if admitted.
Ambulatory Surgical Facility	*Prudent Buyer Plan* - 85% of negotiated rates. Non-*Prudent Buyer Plan* - 65% of covered charges.	100% upon referral by Participating Medical Group.	100% upon referral by Participating Medical Group.	100% at a Kaiser Permanente medical facility, subject to a $5 co-payment.	100% at a Kaiser Permanente medical facility, subject to a $5 co-payment.	Covered at PacifiCare facility, subject to regular co-payment.	Covered at PacifiCare *Secure Horizons* facility, subject to regular co-payment.
Home Health Care	90% of covered charges - only upon referral by Case Management.	$10 co-payment per visit beginning on 31st day of care.	100%.	100% when authorized by a Plan physician for part-time, intermittent care.	100% when authorized by a Plan physician for part-time, intermittent care.	100% as medically necessary and as authorized by your Primary Care Physician.	100% as medically necessary and as authorized by your Primary Care physician.
Hospice Care	90% of covered charges - only upon referral by Case Management.	100% when determined medically necessary by Participating Medical Group.	Not covered.	100% when selected as alternative to traditional services and authorized by a Plan physician.	100% when selected as alternative to traditional services and authorized by a Plan physician.	180 day lifetime.	210 days; may be extended.
Durable Medical Equipment	75% of Schedule of Allowances – see footnote #3.	NOT COVERED.	100%.	100% when prescribed by a Plan physician and in accordance with Health Plan DME Formulary guidelines.	100% when prescribed by a Plan physician and in accordance with Health Plan DME Formulary guidelines.	100%.	100% when prescribed by Plan physician.
Physician Fees: Office Visits Surgery Physical Exam	 75% of Schedule of Allowances – see footnote #3 less $20 co-payment per visit. $20 co-payment waived for Medicare eligible individuals. 75% of Schedule of Allowances – see footnote #3. Up to $200 per Plan Year for retirees and their spouse only. Children not covered.	 100% after $5 co-payment per visit. 100%. 100% after $5 co-payment.	 100% after $5 co-payment per visit. 100%. 100% after $5 co-payment.	 100% after $5 co-payment per visit. Inpatient - 100% Outpatient - 100% after a $5 co-payment. 100% after a $5 co-payment.	 100% after $5 co-payment per visit. Inpatient - 100% Outpatient - 100% after a $5 co-payment. 100% after a $5 co-payment.	 100% after $5 co-payment per visit. 100%. 100% after a $5 co-payment. Well-baby covered in full.	 100% after $5 co-payment per visit. 100% in hospital. 100% after a $5 co-payment, regardless of age.
Diagnostic X-Ray and Laboratory	75% of Schedule of Allowances – see footnote #3.	100%.	100%.	100%.	100%.	100%.	100%.
Chiropractic Benefits	$10 per visit, limit of 12 visits per Plan Year. Physician office visit co-payment does not apply. Chiropractic x-rays limited to $65 per Plan Year.	NOT COVERED.	100% after $5 co-payment per visit, not to exceed 20 visits per calendar year. Annual benefit for chiropractic appliances is $50.	NOT COVERED.	$5 co-payment per visit for manual manipulation of the spine as diagnosed by x-ray and prescribed by a Plan physician.	NOT COVERED.	100% after $5 co-payment per visit, up to 20 visits per year. Annual maximum benefit for chiropractic appliances is $50.

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Mental Health Outpatient	50% of Schedule of Allowance per visit up to 40 visits per Plan Year. Physician office visit co-payment does not apply.	100% after $30 co-payment per visit, not to exceed 20 visits per calendar year.	100% after $20 co-payment per visit.	Individual Therapy: 100% after $20 co-payment per visit; Group Therapy: 100% after $10 co-payment per visit. Maximum: 20 visits per calendar year. Unlimited for AB88 conditions.	Individual Therapy: 100% after $20 co-payment per visit. Group Therapy: 100% after $10 co-payment per visit. No visit limit. Unlimited for AB 88 conditions.	100% after $5 co-payment per visit, up to 30 visits per calendar year. Serious mental illness covered.	100% after $10 co-payment per visit. No limit on number of visits as long as authorized by *Secure Horizons*.
Alcohol/Substance Abuse	Not covered.	Not covered.	100% after $20 co-payment per visit.	100% after $5 co-payment per visit (no visit limit).	100% after $5 co-payment per visit (no visit limit).		100% after $5 co-payment per visit.
OTHER BENEFITS							
Vision Care	Optional vision benefit is available provided through VSP at an additional monthly cost of $16. Payable every 12 months for exam, lenses and frames. $10 deductible for exam and $10 deductible for lenses and frames. Refer to Group #00860000, Division 8, Class 4.	Health Net provides for an eye exam only at 100% after a $5 co-payment per exam. Optional vision benefit is available provided through VSP at an additional monthly cost of $16 – see Managed Health Care Plan for benefits.	*Seniority* Plus provides for an eye exam at 100% after a $5 co-payment per exam; Frames up to $100 allowance every two years; Lenses once every 12 months, if prescription changes. Optional vision benefit is available provided through VSP at an additional monthly cost of $16 – see Managed Health Care Plan for benefits.	Kaiser provides for an eye exam only at 100% after a $5 co-payment per exam. Optional vision benefit is available provided through VSP at an additional monthly cost of $16 – see Managed Health Care Plan for benefits.	*Senior Advantage* provides for an eye exam at 100% after a $5 co-payment per exam; Frames up to $35 allowance every two years; Lenses up to $48 allowance every two years. Optional vision benefit is available provided through VSP at an additional monthly cost of $16 – see Managed Health Care Plan for benefits.	Pacificare provides for an eye exam only at 100% after a $5 co-payment per exam. Optional vision benefit is available provided through VSP at an additional monthly cost of $16 – see Managed Health Care Plan for benefits.	*Secure Horizons* provides for an eye exam at 100% after a $5 co-payment once a year; Frames and lenses after a $20 co-payment every two years. Optional vision benefit is available provided through VSP at an additional monthly cost of $16 – see Managed Care Plan for benefits.
Dental Care	Optional dental benefit is available provided through Delta Dental at an additional monthly cost of $38 whether you enroll in the Managed Health Care Plan or HMO Plan. Provided through Delta Dental Plan of California. Free to choose any dentist but higher out-of-pocket cost if a non-Delta Dental dentist is used. Each dental procedure is payable based on "Table of Allowance" maximum up to $1,000 per individual per Plan Year. $50 deductible for individual per Plan Year but not to exceed $150 per family. Orthodontic care not covered. Refer to Group #2209-0004.						Whether you elect the optional dental coverage provided through Delta Dental, *Secure Horizons* provides benefits at participating dental office, with a co-payment, depending on procedure rendered.
Prescription Drugs	Prescription Solutions benefits provided through Fund. <u>Retail</u> – Participant pays co-payment per prescription below. 30 day supply maximum per prescription: Generic - $10 Formulary Brand Name - $20 Non-Formulary Brand Name - $30 <u>Mail Order</u> – Participant pays co-payment per prescription below. 90 day supply maximum per prescription: Generic - $20 Formulary Brand Name - $40 Non-Formulary Brand Name - $60 If a generic equivalent is available and Participant or Physician prefer brand name, Participant is responsible for the difference in cost between generic and brand name. <u>Maximum</u> - $5,000 per calendar year combined retail and mail order.	$7 co-payment per prescription at Health Net participating pharmacies for a **30 day supply** of generic or prescribed, medically necessary brand name drugs listed in the Health Net Formulary. No maximum. <u>Mail Order</u> - $14 co-payment per prescription; **90 day supply**.	$7 co-payment per prescription at Health Net participating pharmacies for a **30 day supply** of generic or prescribed, medically necessary brand name drugs listed in the Health Net Formulary. No maximum. <u>Mail Order</u> - $14 co-payment per prescription; **90 day supply**.	$7 co-payment per prescription at Kaiser Permanente pharmacies; **100 day supply** of generic or prescribed, medically necessary brand name drugs in accordance with Health Plan Formulary guidelines. No maximum.	$7 co-payment per prescription at Kaiser Permanente pharmacies; **100 day supply** of generic or prescribed, medically necessary brand name drugs in accordance with Health Plan Formulary guidelines. No maximum.	$7 co-payment per generic or $14 co-payment per brand name prescription at any PacifiCare participating pharmacy; **30 day supply**. <u>Mail Order</u> - Two co-payments for **90 day supply**.	$7 co-payment per generic or $14 co-payment per brand name prescription at any *Secure Horizons* contracting pharmacy; **30 day supply**. No maximum. <u>Mail Order</u> - $5 co-payment for **90 day supply**.
Monthly Premium	See rate sheet.						
Toll-Free Numbers	1-800-244-4530	1-800-638-3889	1-800-596-6565	1-800-464-4000 Refer to Group 32901 when calling.	1-800-814-0888 Refer to Group 32901 when calling.	1-800-624-8822	1-888-422-6000

[1] Preferred Provider Plan (Prudent Buyer Plan) Service Area extends to all 46 Northern California Counties.
[2] 90% of covered expenses for facility charges only; 75% for professional fees, diagnostic x-rays and laboratory.
[3] Schedule of Allowances based on negotiated rates if *Prudent Buyer Plan* Provider used or UC&R if Non-*Prudent Buyer Plan* Provider used.

THIS COMPARISON 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 FUND'S RULES AND REGULATIONS OR EACH HMO'S CONTRACT.

Revised 7/28/2003