Laborers Funds Administrative Office of Northern California, Inc.
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Important Plan Benefit Changes

Date: June 30, 2015

To: All Plan Participants and Eligible Dependents

RE: **Laborers Health and Welfare Trust Fund for Northern California**

- Active Plan
- Special Plan for Active Employees
- Retired Plan

Dear Plan Participant and Eligible Dependents:

This announcement outlines several changes and one clarification to the above-referenced Plans that were approved by the Board of Trustees at their meeting of June 3, 2015. Please read each section carefully and if you have questions about how a change may apply to you or your eligible Dependents, call the Trust Fund Office.

If you are enrolled in the Direct Payment Plan through the Active Plan or Special Plan for Active Employees, you will also receive an updated Summary of Benefits and Coverage (SBC) Form with this mailing. The new SBC will cover the period 09/01/2015 – 05/31/2016 and will reflect changes regarding the Maximum Plan Allowance (see Plan Change #2 for more information) effective September 1, 2015.

Plan Change #1: Domestic Partners – Active Plan and Special Plan for Active Employees

This change applies if you are enrolled in either the Direct Payment or Kaiser Permanente Plan.

The term "Individual Employer" means any employer who is required by a collective bargaining agreement with the "Union" to make contributions to the Laborers Health and Welfare Trust Fund for Northern California.

Effective September 1, 2015, you will be permitted to enroll a Domestic Partner in the Plan (including Dependent children of the Domestic Partner to the age of 26), under certain circumstances, as described below and on the next page:

1. You must be working for an Individual Employer that has a job contract with:

   - The City **or** County of San Francisco;
   - City of Oakland;
   - City of Sacramento;
   - County of San Mateo; or
   - The State of California; **and**

2. You must supply the Trust Fund Office with the following:

   - A written statement from the Individual Employer verifying that they have a job contract with any of the agencies listed above;

   - If the Individual Employer has entered into a contract with the **state of California**, along with the written statement verifying that they have a job contract with the state, the Individual Employer must also certify that the cumulative amount of the contract is **$100,000 or more during the fiscal year**;

- If the Individual Employer has entered into a contact with the **City or County of San Francisco**, **City of Oakland** or the **City of Sacramento**, you must provide a copy of your Domestic Partner certificate issued ***by the city or county***;

- If the Individual Employer has certified that they have entered in to a job contract with the **county of San Mateo** or the **state of California**, you and your domestic partner must be registered as Domestic Partners with the California Secretary of State and provide a copy of that certificate; **and**

- You must complete an Enrollment Form.

All regular Plan benefits apply to Domestic Partners. Regular Plan benefits **with the exception of** the Dependent Death Benefit apply to enrolled Dependent children of the Domestic Partner.

Once you have stopped working for an Individual Employer that has a contract with any of the entities listed in #1, eligibility under the Plan will end for the domestic partner and any eligible Dependent of the domestic partner.

Plan Change #2: Value-Based Sites and Maximum Plan Allowance (MPA) – Active Plan, Special Plan for Active Employees and Retired Plan (not eligible for Medicare)

This change applies to the Direct Payment Plan and only for Eligible Individuals who live within California.

Effective September 1, 2015, a **M**aximum **P**lan **A**llowance (MPA) for **Hospital charges** in connection with 4 specific surgical procedures will apply. This means that there is a maximum dollar amount that the Plan will allow on Hospital charges. The MPA does not apply to the surgeon's charge or other non-Hospital-related expenses in connection with the procedure.

PROCEDURE	MPA
Routine total hip or knee replacement surgery	$30,000
Arthroscopy procedures (non-emergency outpatient)	$6,000
Cataract procedures (non-emergency outpatient)	$2,000
Colonoscopy procedures (non-emergency outpatient)	$1,500

With the implementation of the MPA, you will have an incentive for using certain Anthem Blue Cross, Prudent Buyer Plan, Participating Providers and Hospitals referred to as **Value-Based Sites.**

Value-Based Sites include:

- Specific "Designated Hospitals" for routine total hip or knee replacement surgery; **and**

- **A**mbulatory **S**urgical **C**enters (ASC) for non-emergency outpatient arthroscopy, cataract and colonoscopy procedures.

An **A**mbulatory **S**urgical **C**enter (ASC) is a **non-Hospital based facility** where surgery is performed on a same-day basis—it is a Hospital alternative.

If you choose to use a Value-Based Site Designated Hospital for routine total hip or knee replacement surgery, those Designated Hospitals have agreed with Anthem Blue Cross to hold their charges within the $30,000 MPA. In that case, you will only be responsible for your usual coinsurance[1].

Travel-related Expenses: If you must travel more than 50 miles from your home to a Designated Hospital, the Fund will provide reimbursement for up to $750 for mileage, hotel and meals expenses. You will be asked to supply receipts and complete a form to apply for this benefit. Reimbursement by the Fund for these expenses may be considered taxable income by the IRS. Contact the Trust Fund Office for the necessary form.

If you choose to use a Value-Based Site Ambulatory Surgical Center (ASC) for non-emergency arthroscopy, cataract or colonoscopy procedures, you will not need to worry about the MPA at all. You will be responsible only for your annual Plan Year Deductible and the Plan's usual coinsurance.

If you choose not to use a Value-Based Site, you will be financially responsible for all charges that exceed the MPA plus your annual Plan Year Deductible and the Plan's usual coinsurance. Expenses you pay which exceed the MPA will not count toward your annual cost-sharing limit under the Plan Year Out-of-Pocket Maximum[1].

[1]**: Exceptions – If you do not have access to a Value-Based Site or if services cannot be obtained at a Value-Based Site within a reasonable time or travel distance; and/or if the quality of services could be compromised by using a Value-Based Site, the Maximum Plan Allowance (MPA) may not apply.**

If you are planning to have any of the 4 procedures listed in the table on page 2, call the Trust Fund Office for further advice on how you can save money by using a Value-Based Site.

Plan Change #3: Future Moms Program – Active Plan and Special Plan for Active Employees

This change applies to the Direct Payment Plan only.

Important: Pregnancy related services are covered only for female Participants or the spouse of a Participant. Pregnancy related services are not covered for Dependent children.

The Future Moms Program is designed to identify pregnancy risks early so you get the quality care you need to have a successful pregnancy, delivery, and a healthy baby. You are not required to participate in the Program, however, we believe, that once you understand the benefits of the Program, that you will use the Program to its fullest. Plus there is no additional cost to you to use the Program. Once you're registered with the program (***on or after September 1, 2015)*** you can then begin to take full advantage of all the Program has to offer:

- A toll-free telephone number where you will have a nurse coach available to you 24/7 to answer questions you may have about your pregnancy;
- Screenings to see if you might be at risk for depression or early delivery; **and**
- Useful tools for you, your Physician and your nurse coach.

Here's what you need to do:

On or after September 1, 2015, call the Anthem Blue Cross Future Moms Program at 1 866 664 5404 to register with the Program. One of the Program's registered nurses will help you get started.

Generally, you have to register within the first 12 weeks of pregnancy. If, however, you are further along in your pregnancy than 12 weeks as of September 1, 2015 when the program begins, you can still take advantage of the valuable services offered through the Program for the remainder of your pregnancy.

Plan Change #4: Vision Coverage Network – Active Plan, Special Plan for Active Employees and Retired Plan

This change applies if you are enrolled in either the Direct Payment or Kaiser Permanente Plan. If you are a Retired Participant, this applies to you only if you are enrolled in the optional vision coverage.

- **Prior to September 1, 2015**, your vision network was through EyeMed Vision Care, the Select "H" network.

- **Effective September 1, 2015**, your vision network will be through Anthem Blue Cross **"Blue View Vision"** network. This new network includes all of the same providers as under the EyeMed Vision Services Select H network but includes vastly more vision service network providers.

  If you are satisfied with your current EyeMed vision care provider, you do not need to make any changes. If you would like to see what other vision care providers are available to you:

  1. Go to www.anthem.com/ca.
  2. On the right-hand side, click on "Find a Doctor."
  3. Use "Search by selecting a plan/network."
  4. Select the state using the drop-down menu.
  5. Select a plan/network using the drop-down menu:
     ➔ Vision
        ➔ Blue View Vision
  6. Click on "Select and continue."
  7. Under "Located Near," enter a zip code, city and state, address or state and county name.
  8. Click on "Search."

Plan Change #5: Death Benefits for Participants – Active Plan and Special Plan for Active Employees

Death Benefit of Totally Disabled Former Participants (not Dependents)

- **Prior to September 1, 2015**, if you were an Active Plan or Special Plan for Active Employee Participant (not a Dependent) and you were 1) under the age of 60 **and** 2) totally disabled when your eligibility under the Active Plan or Special Plan for Active Employees ended, you were permitted to **"extend"** the Plan's Death Benefit **until the earlier of** 1) your 65th birth date **or** 2) you were no longer totally disabled.

- **Effective September 1, 2015**, the **"extension"** is being eliminated from the Active Plan and Special Plan for Active Employees. If, however, you qualified for the **"extension"** of the Death Benefit **prior to September 1, 2015**, the "extension" of the benefit will continue until the earlier of 1) your 65th birth date or 2) you are no longer disabled.

Plan Change #6: Death Benefits for Dependents – Active Plan and Special Plan for Active Employees

Death Benefit for Dependents

- **Prior to September 1, 2015**, the Dependent's Death benefit for eligible Dependent children was based upon the child's age at death: 24 hours but less than 2 years: $500; 2 years but less than 5: $750; and 5 years but less than 26: $1,000.

- **Effective September 1, 2015,** the Dependent Death benefit will be $1,000 to the age of 26.

Extended Death Benefit for Dependents

- **Prior to September 1, 2015**, if the Dependent of a deceased Participant died within 6 months following the date the Participant would have no longer been eligible for benefit under the Active Plan or Special Plan for Active Employees, the Fund would have paid the Dependent Death benefit, subject to all other plan provisions, to the designated beneficiary.

- **Effective September 1, 2015,** in order for the Dependent Death Benefit to be payable by the Fund, death must occur while the Participant and Dependent are eligible for benefits under the Plan. The six month "extension" is being eliminated.

Plan Change #7: Physical Examination Benefit for Dependents – Retired Plan

- **Prior to September 1, 2015**, physical examination and any x-ray or laboratory examinations were covered up to a maximum of $300 per Plan Year (including any charges for related x-ray and lab fees) for each Retired Plan Participant or Dependent spouse only—Dependent children of Retired Plan Participants were not covered.

- **Effective September 1, 2015,** physical examination and any x-ray or laboratory examinations will be covered:

    a. Up to a maximum of $300 per Plan Year (including any charges for related x-ray and lab fees) for each Retired Plan Participant or Dependent spouse; or

    b. Up to a maximum of $200 per Plan Year (including any charges for related x-ray and lab fees) for each Dependent child of a Retired Plan Participant who is over the age of 2.

Plan Clarification: Eligibility Rule – Active Plan

Effective July 1, 2015:

- An Active Participant who retires with at least 440 hours in his hour bank on the date of his retirement will continue eligibility under the Active Plan for 3 additional months by using the remaining hours in his hour bank.

- Dependents of an Active Participant who dies with at least 440 hours in his hour bank on the date of his death will continue eligibility under the Active Plan for 3 additional months by using the remaining hours in his hour bank.

If you should have any questions concerning the Plan benefit changes or this announcement, contact the Trust Fund Office at 707 864 2800 or toll-free at 800 244 4530, Monday through Friday between the hours of 8:00 A.M. and 5:00 P.M.

Sincerely,

Board of Trustees

This announcement is intended to be a brief summary of the Plan changes. It cannot describe each and every Plan provision that may be relevant to your situation. You should always refer to your Plan booklet for the full details of your Plan. You should keep all Important Plan Benefit Change announcements with your Plan booklet so it contains up-to-date information.

Receipt of this announcement does not validate your eligibility under the Plan. You should always call the Trust Fund Office to verify your eligibility prior to any service.

Grandfathered Health Plans under the Affordable Care Act (ACA)

The Laborers Health and Welfare Trust Fund—Active Plan and Special Plan for Active Employees—are "grandfathered health plans" under the **Patient Protection and Affordable Care Act (the Affordable Care Act) or ACA.** As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted (March 23, 2010). Being a grandfathered health plan means that the Plans may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the Laborers Funds Administrative Office for Northern California, Inc. at the address indicated above. The Plans are also governed by ERISA. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 866 444 3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Keep this announcement with your Health and Welfare Plan booklet:
Insert #15, Active Plan, March 2006 Health and Welfare Plan booklet
Insert #16, Special Plan for Active Employees, March 2006 Health and Welfare Plan booklet
Insert #17, Retired Plan, March 2007 Health and Welfare Plan booklet