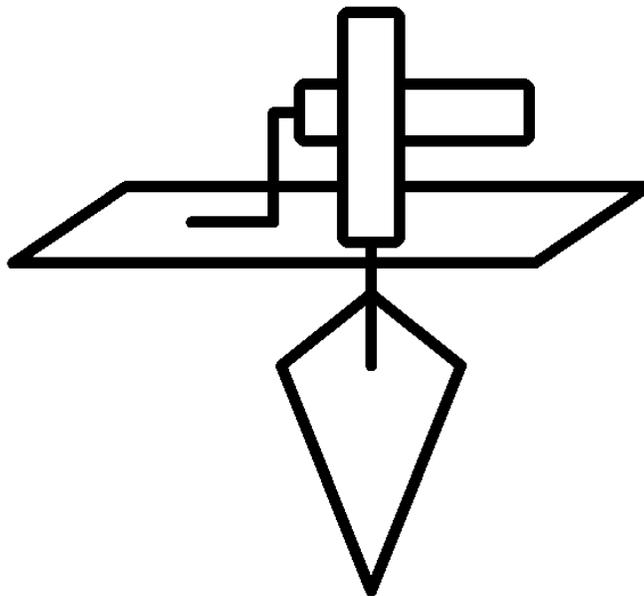


**CEMENT MASONS
HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA**

ACTIVE AND RETIRED PLAN



Summary Plan Description
June 1, 2016

**For the complete Cement Masons Health and Welfare Plan
Rules and Regulations, visit our website at www.norcalcementmasons.org**

**CEMENT MASONS
HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA**

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To: All Active and Retired Cement Masons

We are pleased to provide you with this updated Summary Plan Description (SPD) which describes your Health and Welfare benefits effective June 1, 2016.

While most of the information in this SPD pertains to the **Direct Payment Plan**, other information contained in the SPD applies whether you are covered under the Direct Payment or the Kaiser Permanente Plan and will be identified throughout the SPD.

This SPD is based upon the official Plan Rules and Regulations—you and your eligible Dependents have a right to have a copy and may request one by calling the Trust Fund Office. The Plan Rules and Regulations can also be read, downloaded or printed from the Funds' website at NorCalCementMasons.org.

In the event of any conflict between the SPD and the Plan Rules and Regulations, the official Rules and Regulations will always prevail.

If you are covered under the **Kaiser Permanente Plan**, you should refer to your "Evidence of Coverage (EOC)/Disclosures", which outlines the benefits, limitations and exclusions that govern the Kaiser Permanente Plan.

From time-to-time, the Board of Trustees ("Board") may make changes to the Direct Payment Plan, either in the benefits or the Plan rules. You will be informed of these changes in Important Plan Benefit Change Announcements. You should keep all announcements with this SPD. Announcements can also be read, downloaded or printed from the Funds' website.

Only the Board is authorized to resolve any questions concerning the interpretation of the plan of benefits described in this SPD. No employer or union, nor any representative of any employer or union is authorized to interpret this Plan on behalf of the Board—nor can any of these entities act as an agent of the Board.

Keep this SPD in a handy location and refer to it when you have questions about your Health and Welfare Plan. Share this SPD with your Dependents who are also covered by the Plan. If you have questions about your benefits or how a rule may affect you or your eligible Dependents, call or write the Trust Fund Office.

In order to be covered for any benefits outlined in this SPD or the Kaiser Permanente Plan, you must be eligible at the time the covered health care services are provided to you.

This SPD is available in the Spanish language. If you would like to have a copy of this SPD in Spanish, please call the Trust Fund Office to request that one be mailed to you.

Esta Descripción Resumida del Plan (SPD, por sus siglas en inglés) está disponible en el idioma español. Si desea tener una copia de esta SPD en español, favor de llamar a la Oficina del Fondo Fideicomiso para solicitar que le envíen una por correo.

Sincerely,

June 1, 2016

Board of Trustees

Other Information

- Wherever any words are used in this SPD in the masculine gender, they should be considered as though they were also used in the feminine gender and vice versa.
- Wherever any words are used in this SPD in the singular form, they should be considered as though they were also used in the plural form and vice versa.

The Health and Welfare Trust Agreement

The Trust Agreement provides that Individual Employers are only required to make payments or contributions to the cost of the operation of the Fund or of the Plan, which are contained in a collective bargaining agreement, subscriber's agreement or the Trust Agreement.

Table of Contents

Glossary of Plan Terms	1
Introduction	1
The Healthy Structures—Your Tools for a Smart Finish	4
Active and Retired Participants and Eligible Dependents (Not Eligible for Medicare).....	4
The Affordable Care Act	5
Active and Retired Participants and Eligible Dependents (Not Eligible for Medicare).....	5
Summary of Benefits and Coverage (SBC) form.....	5
The Health Insurance Marketplace.....	6
Patient Protection Rights of the Affordable Care Act	6
Nondiscrimination in Health Care	7
Eligibility	8
Becoming Eligible as an Active Participant.....	8
Initial Eligibility	8
Continuing Eligibility	9
Termination of Eligibility	10
Termination of Your Dependents Eligibility.....	11
How Do I Regain Eligibility?.....	11
Can I Lose The Hours in My Hour Bank?	11
What is “Reciprocity Credit” and How Can I Receive it?	11
Military Service.....	12
USERRA Continuation Coverage	12
Cost for USERRA Continuation Coverage	12
TRICARE	12
After Discharge from Military Service	12
Disability Hour Credit—What is it and How Can I Receive it?	13
Becoming Eligible as a Retired Participant.....	14
Initial Eligibility	14
Transitioning from Active Benefits to Retired Benefits	15
Termination of Your Dependents Eligibility	16
Exception: Surviving Spouse Coverage	16

Special Enrollment Provision.....	16
Acquiring a New Dependent.....	16
If You Had Other Health Plan Coverage at the Time You Retired	17
Retired Participant Self-Payment Subsidy.....	17
New Eligible Packets for Active Cement Masons	18
Retired Participants.....	18
Enrolling Your Dependents	19
Active and Retired Participants.....	19
How to Enroll Your Dependents	19
Documents Required to Enroll Dependents.....	20
If You Divorce.....	21
Your Enrollment Responsibility.....	21
Change of Address Notification.....	22
What Happens When Eligibility under the Plan Ends?	23
Consolidated Omnibus Budget Reconciliation Act	23
COBRA Continuation Coverage	23
Qualified Beneficiary	23
Qualifying Events.....	23
Duration of COBRA Continuation Coverage.....	23
Extending COBRA Continuation Coverage in Cases of Disability.....	24
Extending COBRA Continuation Coverage When a Second Qualifying Event Occurs	24
Effect of Medicare Entitlement before a Termination of Employment or Reduction in Hours	24
Effect of Medicare Entitlement after a Termination of Employment or Reduction in Hours ...	25
Benefits Available under COBRA Continuation Coverage.....	25
Duty to Notify the Trust Fund Office.....	25
Timely Notice to the Trust Fund Office	26
How to Notify the Trust Fund Office	26
Where to Send Your Notice of a Qualifying Event.....	27
Electing COBRA Continuation Coverage.....	27
Cost of COBRA Continuation Coverage.....	27

Paying for COBRA Continuation Coverage.....	28
Adding New Dependents under COBRA Continuation Coverage.....	28
Changing Hospital-Medical Plans under COBRA Continuation Coverage.....	29
Changing Dental Plans under COBRA Continuation Coverage.....	29
Termination of COBRA Continuation Coverage.....	29
ACA Health Insurance Marketplace	30
Choice of Hospital-Medical Plans	31
Hospital-Medical Plan Options.....	31
When You Can Change Hospital-Medical Plans.....	32
Choice of Dental Plans.....	33
If You Are an Active Participant.....	33
If You Are a Retired Participant.....	33
If You Are a COBRA Qualified Beneficiary.....	33
Dental Benefit Plan Options.....	34
Open Enrollment for the Dental Plans	35
Retired Participants.....	35
COBRA Qualified Beneficiaries.....	35
The Dental Plan Enrollment Form	36
The Vision Plan.....	37
Vision Service Plan (VSP).....	37
If You Are an Active Participant.....	37
If You Are a Retired Participant.....	37
If You Are a COBRA Qualified Beneficiary.....	37
If You Are a Kaiser Permanente Plan Member	37
Grievance Procedures for Dental and Vision Plans	38
Death and Accidental Death and Dismemberment Benefits	39
Active Participants.....	39
Death Benefits for Active Participants	39
Extended Death Benefits for Former Active Participants.....	39
Accidental Death Benefits for Active Participants	39
Dismemberment Benefits for Active Participants	39

Limitations for the Accidental Death and Dismemberment Benefits.....	39
Exclusions for the Accidental Death and Dismemberment Benefits	40
Naming Your Beneficiary.....	40
Death Benefits for Dependents of Active Participants.....	40
The Direct Payment Plan For Retired Participants and Dependents Eligible for Medicare	41
Enroll for Medicare	41
Covered Expenses	41
Supplemental Hospital Benefits.....	42
Medicare Benefit Period	42
Supplemental Medical Benefits.....	42
No-Cost Preventive Care Services	42
“Private Contracting” and Medicare.....	42
The Direct Payment Plan For Active and Retired Participants and Dependents Not Eligible for Medicare	44
Professional Review Organizations (PRO).....	45
Covered Expenses	45
Case Management Program	47
Maximum Plan Allowance (MPA)	48
Comparison of Benefits	49
Freedom to Choose Your Own Health Care Providers	49
The Preferred Provider Organization (PPO).....	49
The Preferred Provider Plan (PPO Plan)	49
The BlueCard PPO	50
How to Locate a Participating Hospital or Provider that is Part of the Fund’s Preferred Provider Plan Network	50
Non-Participating Hospitals and Non-Participating Providers	50
The Healthy Structures Programs	52
The “Promise” Program for Active Participants and Eligible Spouses	52
The Care Counseling and Pre-Authorization Review Programs	53
The Care Counseling Program	53
Pre-Authorization Review Program for Non-Emergency Outpatient Services	53
The Value-Based Site Program.....	54

Value-Based Sites.....	55
Exceptions to Value-Based Sites.....	55
For Arthroscopy, Cataract or Colonoscopy Procedures	55
For Routine Total Hip or Knee Replacement Surgery	55
Travel-Related Expenses if you use a Designated Hospital.....	56
The Future Moms’ Program— Active Benefit Only.....	56
The Utilization Review (UR) Requirement.....	57
Elective Inpatient Admissions.....	57
Emergency Inpatient Admissions.....	58
Copayments, Deductible and Coinsurance.....	59
Copayments	59
Deductible	60
Active Participants and Eligible Dependents.....	60
Family Deductible	61
Coinsurance	62
Hospital Charges for Outpatient Services	62
Participating Hospitals:.....	62
Non-Participating Hospitals:.....	63
Hospital Emergency Room Services for an Emergency Medical Condition:.....	63
Hospital Charges for Inpatient Services.....	63
Other Covered Expenses (Non-Hospital)	64
Drug Benefit.....	68
Glossary of Terms	68
The Pharmacy Benefit Manager (PBM)—OptumRx	68
Maintenance Medications	69
Mail Service Pharmacy	69
Formulary Drugs.....	69
Covered Drug Expenses.....	69
Excluded Drugs.....	70
If You Use a Non-Contracting Pharmacy	71
Drug Benefit Copayments.....	71
Preventive Care Services	71
Plan Year Out-of-Pocket Maximum for Covered Drugs	73
What counts toward the Plan Year Out-of-Pocket Maximum for the Plan’s Drug Benefits? ...	73
Third Party Liability.....	74

Benefits Required by Law	75
Newborns’ and Mothers’ Health Protection Act	75
ACA Mandated Benefits.....	75
Women’s Health and Cancer Rights Act (WHCRA).....	75
 Exclusions, Limitations and Reductions	 76
 Other Insurance—Coordination of Benefits	 78
The Order of Benefit Determination—Primary or Secondary	78
 Claims and Appeals Procedures for the Direct Payment Plan	 80
Claims	80
What is a “Claim”?	80
What is Not a “Claim”?	80
What is an “Adverse Benefit Determination”?	80
What is an “Independent Review Organization (IRO)”?	81
What is a “Rescission” of Coverage?	81
Claims Procedures	81
What Must be Included on a Claim?	81
Types of Claims	82
Pre-Service Claims.....	82
Urgent Care Claims.....	83
Concurrent Claims	84
Post-Service Claims.....	84
Notice of Initial Benefit Determination.....	85
How to appeal an Adverse Benefit Determination through the Internal Appeals Procedures	86
Authorized Representative	86
The Internal Appeals Procedures.....	86
When You Can Expect a Decision through the Internal Appeals Process	87
Content of the Appeal Decision Notice	87
External Review Process	88
1. External Review of Standard (Non-Urgent) Claims	88
2. External Review of Expedited Urgent Care Claims.....	90
Limit on When You May Begin a Lawsuit (Civil Action)	91
 Information Required Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996	 92
Privacy of Your Health Information under HIPAA	92
Privacy Notice.....	92

Changes to the Privacy Notice	93
Other Privacy Notices.....	93
Who Sees Your Health Information?.....	93
The Health Plan’s Promise to You	93
How the Health Plan Uses and Discloses Your Health Information.....	93
Treatment.....	94
Payment	94
Health Care Operations.....	94
Required By Law	94
To Prevent Serious Threats to Health or Safety	94
Special Situations.....	95
Your Rights Regarding Health Information the Plan Maintains about You	95
Other Uses of Medical Information	97
Where to Obtain HIPAA PHI Forms.....	97
Where to File Complaints or Send Completed HIPAA PHI Forms.....	97
Organizations through Which Benefits Are Administered or Provided	98
Information Required by the Employee Retirement Income and Security Act of 1974 (ERISA)	99
Statement of Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)	101
Receive Information About Your Plan and Benefits	101
Continue Group Health Plan Coverage.....	101
Prudent Actions by Plan Fiduciaries	101
Enforce Your Rights.....	102
Assistance with Your Questions	102

Glossary of Plan Terms

Active Participant	Means an Employee of an Individual Employer who has established eligibility under the Plan.
Advantage PPO network	Means the Fund's Preferred Provider Plan network through Anthem Blue Cross within California.
Affordable Care Act (ACA)	Means the federal health care law signed in to law on March 23, 2010.
Allowed Charge; Allowed Amount; Allowable Charge	Means the maximum dollar amount that the Plan will allow for Covered Expenses. For a Preferred Provider it means the negotiated contract amount. For a Non-Preferred Provider, it means the amount established by an independent review organization retained by the Fund. Neither of which will exceed the provider's billed charges.
<u>Ambulatory Surgical Center (ASC)</u>	Means a licensed free-standing <u>non-hospital based facility</u> where surgery is performed on a same day basis (patient is not kept overnight).
BlueCard PPO	Means the Fund's Preferred Provider Plan network through Anthem Blue Cross outside of California within the United States.
Blue Distinction® Centers	Hospitals recognized for their expertise in delivering specialty care.
Coinsurance	Means the Eligible Individual's share of cost on their Claim represented as a percentage.
Concurrent Review	Means a <u>Utilization Review (UR)</u> that occurs after admission to the Hospital as an inpatient and while still confined as a bed patient.
Copayment	Means an upfront amount that an Eligible Individual pays for a Physician's Office Visit; Hospital Emergency Room Visit; Labor and Delivery charges; Prescription Drugs and Vision Care services.
Covered Charges	Means the Hospital's lowest semi-private or ICU rates or 80% of the Hospital's lowest rate for private rooms when you use a Non-Participating Hospital for an inpatient hospitalization.
Covered Expenses	Means Hospital and medical services and supplies that are covered under the Direct Payment Plan. See pages 49-51.
Deductible	Means an annual Plan Year amount that an Eligible Individual pays toward Covered Expenses before the Plan begins paying benefits.
Deductible Carryover Period	Means the last three months of the Plan Year, October, November and December. Any annual Deductible satisfied during the carryover period will be applied to the Deductible for the next Plan Year.
Dependent	Means: Your lawful spouse, Your natural, adopted or step or foster child(ren) younger than age 26,

Your child or children age 26 and older if they were eligible as a Dependent under the Plan when they reached age 26 and who are prevented from earning a living because of mental or physical handicap—provided that the child(ren) is primarily dependent upon the Participant for support.

Eligible Individual	Means each Active Participant and their eligible Dependents and each Retired Participant and their eligible Dependents.
Emergency Medical Condition	Means a medical condition that without immediate medical treatment would cause serious jeopardy to the health of the Eligible Individual.
Emergency Services	Means outpatient services at a Hospital emergency room for an Emergency Medical Condition.
Employee	Means a person who is working for an Individual Employer and for whom contributions are made or required to be made to the Cement Masons Health and Welfare Trust Fund.
ERISA Plan Year	Means September 1 through August 31 each year. This is the Plan's fiscal accounting period and it is a different period than the benefit Plan Year. See Plan Year.
Fund	Means the Cement Masons Health and Welfare Trust Fund for Northern California.
Group Plan	Means any plan providing benefits of the type provided by this Plan which is supported wholly or in part by employer payments.
Hospital	Means licensed, general acute care Hospitals that provide 24/7 services. Hospital also means licensed free-standing psychiatric treatment facilities and licensed free-standing substance abuse treatment facilities.
Hour Bank	Means an account established for each Employee into which work hours are deposited.
Individual Employer	Means an employer who is required by a collective bargaining agreement or subscriber's agreement to contribute to the Cement Masons Health and Welfare Trust Fund for Northern California.
Local Union	Means any local union affiliated with the Union (see Union) whose members perform work covered by the Cement Masons 46 Northern California Counties Master Agreement.
<u>Maximum Plan Allowance (MPA)</u>	Means a dollar maximum placed on specific Covered Expenses. See Allowed Amounts.
Medically Necessary	Means services that are determined by medical professionals as appropriate and necessary for the symptoms, diagnosis or treatment of an illness or injury.
Non-Participating Hospital	Means Hospital that is not part of the Fund's Preferred Provider Plan.

Non-Participating Provider	Means a Physician, laboratory, radiology facility, <u>A</u> mbulatory <u>S</u> urgical <u>C</u> enter (ASC) or other licensed health care provider that is not part of the Fund's Preferred Provider Plan.
Out-of-Pocket Maximum	Means a Plan Year dollar limit that Eligible Individuals pay for Copayments, Deductible and coinsurance when they use Participating Hospitals or Providers that are part of the Fund's Preferred Provider Plan network or a Hospital for Emergency Services as defined by the Plan.
Participating Hospital	Means a Hospital that is part of the Fund's Preferred Provider Plan network.
Participating Provider	Means a Physician, laboratory, radiology facility, <u>A</u> mbulatory <u>S</u> urgical <u>C</u> enter (ASC) or other licensed health care provider that is part of the Fund's Preferred Provider Plan network.
Plan Year	Means the Benefit Plan Year, January 1 through December 31.
Pre-Admission Review	Means a <u>U</u> tilization <u>R</u> evue (UR) for an elective admission before you are admitted to a Hospital in order to determine the number of Hospital days that are medically necessary for your condition.
Pre-Authorization Review	Means a program under which certain non-emergency outpatient surgeries and other procedures must undergo a review by the Care Counselor or Anthem Blue Cross before you obtain the services.
<u>P</u>referred <u>P</u>rovider <u>O</u>rganization (PPO)	Means a managed care organization of health care providers who have an agreement to accept lower fees for their services. The agreements are between the health care providers and Anthem Blue Cross (not the Fund).
Preferred Provider Plan	Means a program or plan of benefits which uses the services of a <u>P</u> referred <u>P</u> rovider <u>O</u> rganization (PPO) for the provision of medical services at negotiated contract rates.
Preferred Provider Plan Service Area	Means all zip codes for California Counties in which an Eligible Individual lives and are subject to the reimbursement provisions of the Preferred Provider Plan. The Preferred Provider Plan Service Area also includes the BlueCard PPO national network.
<u>P</u>rofessional <u>R</u>evue <u>O</u>rganization (PRO)	Means the company under contract with the Fund to provide services to the Plan for <u>U</u> tilization <u>R</u> evue (UR) and the outpatient Pre-Authorization Review programs.
Retired Participant	Means each former Active Participant who has retired with a pension from the Northern California Cement Masons Pension Plan and who has met all eligibility requirements for participation in the Plan as a Retired Participant.
Retrospective Review	Means a Utilization Review that occurs after discharge from the Hospital when there has been no Pre-Admission and/or Concurrent Review.

Utilization Review (UR)

Means a review that determines the number of Hospital days that are Medically Necessary for a Hospital confinement. There are three different types of Utilization Review:

1. Pre-Admission Review—required on all elective Hospital admissions.
2. Concurrent Review—any Hospital admission.
3. Retrospective Review—takes place after the patient has been discharged when there has been a failure to obtain the required Pre-Admission or Concurrent Review.

Value-Based Site

Means for routine total hip or knee replacement surgery at a Designated Hospital that is part of the Fund’s Preferred Provider Plan network or for outpatient arthroscopy, cataract or colonoscopy procedures, it means an Ambulatory Surgical Center (ASC) that is part of the Fund’s Preferred Provider Plan network.

Introduction

Multiemployer Plan

A multiemployer plan is an employee benefit plan maintained under one or more collective bargaining agreements to which more than one employer contributes. The collective bargaining agreements are between the Union and employer groups. The Cement Masons Health and Welfare Trust Fund for Northern California was established by a Trust Agreement entered into by the Union and Individual Employers. Under the terms of the Trust Agreement, a Plan of benefits was created and is called a multiemployer plan.

Board of Trustees

The Plan is sponsored by a joint Board of Trustees (the Board) consisting of an equal number of representatives from labor and management. The Board is responsible for the overall operation and administration of the Plan.

Active Participants

The plans offered through the Fund provide comprehensive hospital-medical (including prescription Drug) benefits along with dental and vision care benefits to you and your eligible Dependents.

As an Active Participant, you are eligible for a Death, Accidental Death and Dismemberment benefits whether you have selected the Direct Payment or Kaiser Permanente Plan. Your eligible Dependents are also eligible for a Death benefit.

If You Are Retired

You must be eligible to participate in the Plan as a Retired Participant, select plan options and make the required monthly self-payments to the Fund in an amount determined by the Board.

What Are “Self-Funded” Plans?

Self-funded plans are ones in which the Fund assumes the financial risk for providing Plan benefits to Eligible Individuals. The Fund’s self-funded plans are 1) the Direct Payment Plan for hospital-medical and Drug benefits; 2) Delta Dental and 3) the Vision Service Plan.

In order to carry out some of the self-funded administrative duties, the Fund has contracts with various other companies such as Anthem Blue Cross (ABC); Delta Dental of California; OptumRx; the Vision Service Plan (VSP) and Pacific Health Alliance (PHA). The Fund pays a monthly fee to each of these companies to carry out certain administrative duties on behalf of the Fund.

What Are “Fully Insured” Plans?

A fully insured plan is one for which the Fund pays a monthly premium to a plan and the plan assumes the financial risk for providing benefits to Eligible Individuals, such as the Kaiser Permanente Plan, DeltaCare USA and UnitedHealthcare Dental.

Plan Options

Hospital-Medical Plan Options	Dental Plan Options	Vision Plan
The Direct Payment Plan (self-funded)	Delta Dental (self-funded)	Vision Service Plan (self-funded)
Kaiser Permanente (fully insured)	DeltaCare USA (fully insured)	
You may select Kaiser Permanente only if you live within a Kaiser service area in Northern California.	UnitedHealthcare Dental (fully insured) Dental Offices are available only in California.	

You Share with the Fund the Cost of Your Covered Hospital-Medical Care:

- **Copayments**
- **Deductible**
- **Coinsurance**

Coverage Area:

- **If you are enrolled in the Direct Payment Plan:** Coverage is only provided throughout the United States, its Territories and Possessions. Covered Expenses incurred outside of the United States, its Territories and Possessions will be limited to emergency care services only.
- **If you are enrolled in the Kaiser Permanente Plan:** Coverage is only provided at Kaiser Permanente facilities throughout **Northern California**. Coverage outside of **Northern California** is limited to emergency care services only. Consult the Kaiser Permanente Evidence of Coverage/Disclosures.
- **If you are enrolled in the Delta Dental Plan:** Coverage is only provided throughout the United States, its Territories and Possessions. Consult the plan’s summary of benefits, exclusions and limitations.
- **If you are enrolled in DeltaCare USA:** Dental Offices are available throughout the United States—you must pre-select your dental office. Consult the plan’s summary of benefits, exclusions and limitations.
- **If you are enrolled in UnitedHealthcare Dental:** Dental Offices are only available in California. Consult the plan’s summary of benefits, exclusions and limitations.

Medically Necessary

The Direct Payment Plan only provides coverage for “Medically Necessary” care, treatment or services as defined under Article I., Section 36.00 and “Covered Expenses” as defined under Article V., Section 1 of the Plan Rules and Regulations.

Preventive Care Services

The Direct Payment Plan and Kaiser Permanente Plan provide coverage for Preventive Care Services required under the Affordable Care Act (ACA) at no cost to you. If you are enrolled in the Direct Payment Plan, you **must** use a Participating Provider or Contracting Pharmacy. If you are enrolled in the Kaiser Permanente Plan you **must** obtain covered Preventive Care Services at a Kaiser Permanente Plan facility in Northern California.

Experimental or Investigative Procedures

Under the Direct Payment Plan, generally, Experimental or Investigative Procedures are not covered. However, if you are enrolled in an approved clinical trial related to cancer or another life-threatening illness, costs for certain routine services may be covered by the Plan if you have obtained a Pre-Authorization. Call the Trust Fund Office for further details if you are enrolled or are to be enrolled in a clinical trial.

Individual Employer Contributions

Active Participants. All benefits, whether self-funded or fully insured, are primarily paid for from the contributions made or required to be made to the Fund by Individual Employers who are signatory to a collective bargaining agreement or subscriber's agreement between the Union and the employer groups.

Retired Participants. All benefits, whether self-funded or fully insured, are paid for from a combination of Individual Employer contributions (if the Retired Participant qualifies for the self-payment subsidy explained on page 21) and self-payment contributions made by Retired Participants.

Can Plan Benefits or Rules Ever Change?

Yes. Only the Board has the authority to make changes through amendments to the Direct Payment Plan.

The nature and amounts of the benefits are always subject to the actual terms of the Plan as they exist at the time the Claim occurs.

Important Plan Benefit Change Announcements

When there is a change to the Direct Payment Plan, the Kaiser Permanente Plan, one of the dental plans or the vision plan which is considered a "material modification", you will be notified prior to the effective date of the change. However, not all changes are considered material modifications. A material modification is generally a major or a significant change in benefits or Plan rules and will result in amendments to the Plans, Evidence of Coverage or other benefit summaries.

The Healthy Structures—Your Tools for a Smart Finish

Direct Payment and Kaiser Permanente Plan

Active and Retired Participants and Eligible Dependents (Not Eligible for Medicare)

The Board along with your Union and employer have taken steps to address the rising costs of health care that are adversely affecting the hospital-medical plans. The focus of the changes is based on two goals: First, they want you and your eligible Dependents to live the healthiest lives possible; and second, they want you and your eligible Dependents to make smart, informed choices when purchasing health care services. Taking both of these steps will help you save money as well as help the Fund remain financially sound. Beginning in 2011, the Board adopted a concept designed around these two goals called “**Healthy Structures, Your Tools for a Smart Finish**”. Under “**Healthy Structures**”, there are several programs specifically designed to help you obtain the quality health care services you expect and save money for both yourself and the Fund at the same time.



CAUTION: The various Healthy Structures programs described below and in the pages that follow apply to the Direct Payment Plan only with the exception of the Promise program which applies to both the Direct Payment and Kaiser Permanente Plan (see pages 56-58 for more information about the Promise program):

- The Promise program (Active benefits only);
- A Care Counseling (Care Counselor) and Pre-Authorization Review program through Pacific Health Alliance for non-emergency outpatient services;
- Value-Based Site program for routine total hip or knee replacement surgery; non-emergency outpatient arthroscopy, cataract and colonoscopy procedures (**California based only**);
- A new Preferred Provider Plan network, Anthem Blue Cross Advantage PPO, if you live within California;
- A custom Formulary Drug program; **and**
- The Future Moms’ program (Active benefits only).

If you are a Retired Participant or the Dependent of a Retired Participant enrolled in the Direct Payment Plan who is Eligible for Medicare, these programs do not apply to you (see pages 45-47 for your benefits).

Understanding how the Healthy Structures programs work and apply to you and your eligible Dependents, will help you use your health plan to the fullest, receive quality health care services and save money.

The Affordable Care Act

Direct Payment and Kaiser Permanente Plan

Active and Retired Participants and Eligible Dependents (Not Eligible for Medicare)

The new federal health care law, the “Affordable Care Act” (ACA) was signed into law on March 23, 2010.

The ACA law requires that all health plans provide certain consumer protections mandated under the law and includes:

- Coverage for children to the age of 26 regardless of marital or dependency status; **and**
- No annual or lifetime dollar limits on Essential Health Benefits (EHB).

The ACA law also requires that certain health plans provide additional consumer protections if they are “non-grandfathered” plans, like the Cement Masons Health and Welfare Plan.

The Fund’s Direct Payment and Kaiser Permanente Plans are both “non-grandfathered” health plans because each plan experienced significant benefit changes after the law was passed causing each plan to lose its grandfathered plan status.

Non-grandfathered health plans must provide additional consumer protections for:

- Preventive Care Services that are at no cost to you:
 - **Direct Payment Plan:** When you use a Participating Hospital or a Participating Provider that is part of the Fund’s Preferred Provider Plan network or a Contracting Pharmacy, when applicable.
 - **Kaiser Permanente Plan:** When you use a Kaiser Permanente facility in Northern California.
- Emergency Services will be available at any Hospital and will have the same Copayment and coinsurance as if you used a Hospital that is part of the Fund’s Preferred Provider Plan network.

Both the Direct Payment and the Kaiser Permanente Plans meet the Minimum Essential Coverage (MEC) and the Minimum Value Standard (MVS) under the ACA law.

Summary of Benefits and Coverage (SBC) form. The ACA law requires that all health plans provide a completed SBC form to individuals covered under their plans. The Trust Fund Office provides this form:

- At enrollment (see New Eligible packets on page 22);
- Annually before the beginning of the ERISA Plan Year which is September 1st; **and**

- Whenever there is a major or significant change in benefits that affects the information on the SBC.

You can always read or print a copy of the most recent SBC from the Funds' website.

The purpose of the SBC form is so people can easily compare health plans when they are shopping for health plan coverage in the Health Insurance Marketplace which opened in 2014. The Health Insurance Marketplace is a means for organizing health plans into one central location to help consumers shop for coverage in a way that permits easy comparison of available plan options based on price, benefits, services and quality. The SBC form must conform to certain rules and means that the standardized form cannot be altered to fit the Fund's health plans—this is so an easy comparison can be made between multiple plans that are offered in the Health Insurance Marketplace.

Any change in benefits that affects the information on the SBC will generate a new SBC with the effective date of the benefit change through the end of the **ERISA Plan Year, i.e. August 31st**.

Helpful Tips: When you see “**coverage period**” on the SBC, it is referring to the ERISA Plan Year which is the Fund's “fiscal year” or accounting year (September-August). The Fund's “benefit” Plan Year is January-December and is the period in which you and your Dependents accumulate your annual Deductible, your annual Out-of-Pocket Maximum (your annual cost-sharing limits) and the period in which any annual benefit limitations apply.

The Health Insurance Marketplace

While you remain eligible under one of the plans offered by the Fund, you will have no need to shop for individual health plan coverage in the Health Insurance Marketplace.

Generally, you cannot enroll in a Health Insurance Marketplace plan outside of the annual Open Enrollment (OE). There is, however, a “Special Enrollment Period” where certain “**Qualifying Events**”, as defined by the ACA law, permits you and your Dependents to enroll in a Health Insurance Marketplace plan outside of the usual OE period. Special rules may also apply if you have enrolled in COBRA Continuation Coverage. For more information contact www.coveredca.com if you live in California or www.healthcare.gov if you live elsewhere in the United States.

Patient Protection Rights of the Affordable Care Act

This Plan does not require that you or your eligible Dependents select or designate a Prietary Care Physician (PCP). You and your eligible Dependents have the right to visit any Participating or Non-Participating Hospital or Provider, however, payment by the Fund may be less if you use a Non-Participating Hospital or Provider.

Eligible Individuals do not need prior authorization from the Fund or any other entity in order to obtain obstetrical or gynecological care from a health care provider who specializes in obstetrics or gynecology. The health care provider may, however, be required to comply with certain Plan rules, including obtaining prior authorization for certain services, when one is required, and other rules that may exist for making referrals.

Nondiscrimination in Health Care

To the extent that an item or service is a covered benefit under this Plan, the Fund will not discriminate with respect to your choice of a health care provider so long as that health care provider is licensed by the state in which he practices and is operating within the scope of his license.

Eligibility

Direct Payment and Kaiser Permanente Plan

Becoming Eligible as an Active Participant

Two important terms to remember:

1. **Individual Employer.** An “Individual Employer” is one who is required by a collective bargaining agreement to make contributions to the Fund.
2. **Hour Bank.** An “Hour Bank” is an account established for an Employee of an Individual Employer where work hours are recorded and accumulate to provide future benefits.

Initial Eligibility

When you perform work that requires an Individual Employer to make contributions to the Fund on your behalf, your reported work hours are deposited in an “Hour Bank”. When the total in your Hour Bank reaches a minimum of **330 hours**, **110 hours** are deducted to provide you with one month of eligibility beginning on the first day of the **second month** after earning the minimum number of hours. There is a no-eligibility or “lag month” between the month that the **110 hours** are deducted from your Hour Bank and your first month of eligibility. After the **110 hours** are deducted from the Hour Bank, the balance of the hours is carried forward to the next month. The chart below illustrates how the Hour Bank works.

Work Month	November	December	January	February	March	April	May	June
Beginning Hour Bank balance	0	120	270	220	270	305	305	335
Work hours	120	150	60	160	145	None	140	None
Total	120	270	330	380	415	305	445	335
Monthly Deduction	None	None	110	110	110	None	110	110
Eligibility Month	<u>January</u> No Not Eligible in January	<u>February</u> No Not Eligible in February	<u>March</u> Yes Eligible through March 31st	<u>April</u> Yes Eligible through April 30th	<u>May</u> Yes Eligible through May 31st	<u>June</u> No Not Eligible in June	<u>July</u> Yes Eligible through July 31st	<u>August</u> Yes Eligible through August 31st
Hours Carried Forward	120	270	220	270	305	305	335	225

1. November Work Month:

- In your first work month, November, you worked 120 hours. Since the Hour Bank total in November did not reach **330 hours**, you were not eligible for benefits in January.
- The 120 hours are carried forward to your Hour Bank to be used next month, December.

2. December Work Month:

- You work 150 hours in December. In December, your Hour Bank total still has not reached **330 hours** so you are not eligible for benefits in February.
- The total of 270 hours worked in November and December is carried forward to your Hour Bank for January.

3. January Work Month:

- You work 60 hours in January which brings your Hour Bank total in January to **330 hours**. Because the Hour Bank now totals **330 hours** in January, **110 hours** are deducted for one month of eligibility which begins on March 1st (the second month after earning the required minimum number of hours).
- After the deduction of the **110 hours** for March eligibility, the balance of 220 hours is carried forward in the Hour Bank to February.

The Hour Bank continues each month throughout the year.

Continuing Eligibility

Once you have established your initial eligibility month, you must maintain at least **330 hours** in your Hour Bank each month for continuous month-to-month eligibility.



For any month that you work more than the number of hours required to bring your Hour Bank total to the minimum of **330 hours**, the excess hours “accumulate” in your Hour Bank. You may accumulate a maximum of **880 hours** in your Hour Bank after the deduction of the **110 hours**. These extra “banked” hours are valuable and important if you are unable to work the full **110 hours** within a month or you may not be working for one reason or another.

Termination of Eligibility

- The last day of the month following the month in which your Hour Bank balance drops below **330 hours**. See example below.

After adding the work hours for March, the Hour Bank total is more than the required **330 hours**. This means that **110 hours** can be deducted from the Hour Bank for May eligibility (through May 31st). After the **110 hour** deduction, 305 hours are carried forward in the Hour Bank to April. If no hours are worked in April, no deduction can be made for June eligibility. In the example on below, eligibility ends on May 31st because the April Hour Bank total is below **330 hours**.

Example of When Your Eligibility Ends

Work Month	March	April	May
Beginning Hour Bank	270	305	305
Work Hours	145	None	
Total	415	305	
Monthly Deduction	110	None	
Eligibility Month	May	June	July
	Yes Eligible through May 31st	Not Eligible in June . Eligibility ended on May 31st	
Hours Carried Forward	305	305	

Exception 1. If you are an Active Participant who retires with a pension from the Cement Masons Pension Trust Fund for Northern California and you have at least **330 hours** in your Hour Bank on the effective date of your pension, you may use the remaining hours in your Hour Bank for up to 3 additional months of eligibility.

Exception 2. If you are an Active Participant who dies with at least **330 hours** in your Hour Bank and you have enrolled Dependents, your Dependents will be able to use the remaining hours in your Hour Bank for up to 3 additional months of eligibility.

- Your eligibility for benefits ends when you enter military service, other than for a temporary tour of duty of 30 days or less. Special reinstatement rules apply upon your return from active military service for longer periods of time (see Military Service on page 16). For more information, call the Trust Fund Office or refer to the official Plan Rules and Regulations located at the Funds' website.
- Your eligibility ends on the last day of the month when you perform the type of work covered by a collective bargaining agreement for an employer **who is not** an Individual Employer.

- If you die, your eligibility will end on the last day of the month following the month your Hour Bank total drops below the **330 hour** minimum (see the chart on page 12 and **Exception 2** on the previous page).

Termination of Your Dependents Eligibility

- The date your eligibility ends (except in the case of death; see **Exception 2** on the previous page); or if earlier,
- The date your Dependent no longer qualifies as a Dependent under the Plan. However, Dependent children who reach age 26 will be eligible through the end of the month in which they turn age 26.

How Do I Regain Eligibility?

You must work a sufficient number of hours for an Individual Employer to bring your Hour Bank total to **330 hours** within 13 months from the last month of eligibility.

When your Hour Bank total reaches **330 hours**, the required **110 hours** will be deducted from your Hour Bank for one month of eligibility beginning on the first day of the second month following the month your Hour Bank total reaches **330 hours**. See chart on page 12.

Can I Lose The Hours in My Hour Bank?

Generally, hours remain in your Hour Bank until you have worked sufficient hours to gain eligibility. However, if you do not gain eligibility within 13 months from the last month of eligibility, any remaining hours in your Hour Bank will be cancelled.

If you were not able to gain eligibility within the 13 month period because you were disabled, you may petition the Board to reinstate your cancelled hours. Contact the Trust Fund Office for more information.

What is “Reciprocity Credit” and How Can I Receive it?

There may be occasions when you work as a cement mason outside of the Northern California jurisdiction because you have obtained work in another area. There may also be occasions when your employer requests that you perform covered work outside of the Northern California jurisdiction. Regardless of the reason for working outside of Northern California, you should contact your local union office or the Trust Fund Office because under some circumstances, you may be entitled to have contributions for your work hours for the Health and Welfare Plan “follow you” back to your home area—this is called “reciprocity”.

If you do not contact the Trust Fund Office or your local union, you may lose valuable work hours and contributions which would allow you to be eligible for benefits from the Fund. If you do not qualify for the type of “reciprocity”, where contributions “follow you” back to your home area, and you have a Claim for any month in which you are not eligible for benefits under the Fund or in the

jurisdiction where you are working, there may be another form of Reciprocity available **on a per Claim basis**. You should contact the Trust Fund Office if you have questions or to see if you qualify for any form of reciprocity.

Military Service

This section will explain how the Plan works with your rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA), a federal law.

USERRA Continuation Coverage

On the date you enter active duty military service **for more than 30 days**, your eligibility and that of your Dependents will end under the Plan. The Fund, however, must provide you with Plan continuation options and reinstatement rights in accordance with USERRA.

In order for the Fund to provide you with information about USERRA Continuation Coverage, you must first notify the Board as soon as possible but no later than 60 days from the date you enter active duty military service. When the Trust Fund Office, on behalf of the Board, receives your notice, you will be provided with information about your rights to continue your health plan coverage through self-payments under USERRA Continuation Coverage for up to 24 months **or** COBRA Continuation Coverage for up to 18 months.

Cost for USERRA Continuation Coverage

The cost for USERRA Continuation Coverage is determined in the same way as for COBRA Continuation Coverage. See “Cost of COBRA Continuation Coverage” on pages 31-32.

TRICARE

When you are on active duty or retired military, you may also have access to coverage through TRICARE, the Department of Defense health care program for uniformed service members and their family. If this option is available to you, you should contact TRICARE for information about enrollment and how TRICARE works with any other Group Plan or Medicare.

After Discharge from Military Service

When you are discharged from active duty military service (not less than honorably), on the date you return to work or you make yourself available for work as a cement mason within the jurisdiction of the Fund for an Individual Employer and within the period during which you have re-employment rights under USERRA, your Hour Bank and eligibility will be reinstated to the same level as on the date you entered military service **if you have filed notice on a form that has been approved by the Board and within the following time frames:**

- **For military service of less than 31 days:** The Participant must file notice with the Board at the beginning of the next regularly scheduled work period on the day following discharge (plus travel time and an additional 8 hours).

- **For military service of 31 days but less than 181 days:** The Participant must file the notice with the Board within 14 days from the date of discharge; **or**
- **For military service of 181 days or more:** The Participant must file the notice with the Board within 90 days from the date of discharge;

If a Participant is hospitalized or is convalescing from an injury caused by his active duty, these time frames will be extended by two years.

Disability Hour Credit—What is it and How Can I Receive it?

Disability Hour Credit will help to extend your eligibility during periods in which you are unable to work due to disability.

If you become disabled while working as a cement mason for an Individual Employer **and** your Hour Bank contains at least **330 hours** in the month in which you become disabled, you may be entitled to Disability Hour Credit.

You may receive Disability Hour Credit at the rate of 8 hours per day, 40 hours per week not to exceed **110 hours** per month. You may receive a maximum of **660 hours** during any 12-consecutive month period.

In order to receive Disability Hour Credit, request a Disability Certification form from the Trust Fund Office, your local union office, or you can print the form from the Funds' website (see sample below). Your doctor must complete Part I; you must complete Parts III and IV. Part II is for Disability Hour Credit from the Cement Masons Pension Trust Fund for Northern California.

Below is the current Disability Certification form in use as of the printing of this SPD. Always check the Trust Funds' website for the most recent form.

DISABILITY CERTIFICATION

Cement Mason's Name _____ Social Security No. _____

Part I. Cement Masons Health & Welfare Plan Disability Hours Credit – PHYSICIAN must complete this section.

NOTE: A doctor's certification of disability must be filed with the Fund Office within one YEAR from the onset of the disability, otherwise, it will not be accepted for purpose of granting Health and Welfare disability hours.

This is to certify that the above-named was absent from Covered Employment as a Cement Mason due to disability for the period from _____ to _____

Nature of disability is/was _____

Date you first examined patient for above condition _____

Physician's Name (print) _____ Telephone No. _____

Address _____

Physician's Signature _____ Date _____

Part II. Cement Masons Pension Plan Disability Hours Credit – CEMENT MASON must complete this section.

NOTE: The Cement Mason should complete this portion ONLY if he received Workers' Compensation or State Disability Insurance during the above disability period. **THIS IS NOT AN APPLICATION FOR A DISABILITY PENSION.**

The undersigned certifies:

1. That the disability is/was (check one): Occupational Non-occupational

2. That benefits have been paid by (check one): Workers' Compensation State Disability Insurance

3. If paid by Workers' Compensation, benefits were (check one): Temporary Permanent Disability Benefits

NOTE: Disability Hours credit cannot be granted if you have been deemed permanently disabled by Social Security Administration and you are receiving Social Security Disability Benefits. Please send a copy of your Social Security Award Notice to the Fund within 12 months of the issued date.

4. That the insurance carrier or name of agency making the payments described in Item No. 2 above is/was: _____

5. That payments have been made (indicate dates) from _____ to _____

6. That the nature of the disability is/was _____

7. That the last day I worked as a Cement Mason prior to my disability was _____

Part III. Cement Mason's Authorization for Release of Medical Information - Cement Mason must sign below.

The undersigned patient authorizes any provider of health care, physician or other practitioner, hospital, insurer, self-insurer, consumer reporting agency, employer, union or other labor organization or group policyholder to furnish and disclose to the Cement Masons Health and Welfare Trust Fund for Northern California and the Cement Masons Pension Trust Fund for Northern California, or any person or entity representing the Funds, all records or other information in their control or within their knowledge concerning the Cement Mason's medical history, physical or mental condition, or any consultation, prognosis, diagnosis or treatment, for use solely in the processing of the claim for disability credit, including any procedure for the coordination of benefits or for reciprocity. The undersigned also authorizes the Funds or any person or entity representing the Funds, to acquire, retain, utilize and disclose information for the purpose of processing the claim for disability credit, including the disclosure to any provider of health care, insurer, self-insurer, hospital, health care service plan or employer, union, or other labor organization, or any person or entity representing any of the foregoing. This authorization will remain valid until the claim has been processed, including any procedure for review or re-activation of the claim after having been processed. The undersigned has the right to receive a true copy of this signed authorization on request. This authorization is intended to be a valid authorization in accordance with California Civil Code Section 56.10 and is construed to give effect to that intention. A photocopy of this authorization is as valid as the original.

Cement Mason's Signature _____ Date Signed _____

Part IV. Cement Mason's Statement – CEMENT MASON must complete and sign this section.

The undersigned declares under penalty of perjury that the foregoing is true and correct.

Cement Mason's Signature _____ Date Signed _____

Address _____

Telephone No. _____ Local Union No. _____

RM 3004 Rev. 10/2009 **Please return completed form to:**
Cement Masons Pension Trust Fund for Northern California, 220 Campus Lane, Fairfield, CA 94534-1499



Filing Deadline: To be considered for Disability Hour Credit under the Health and Welfare Plan, your completed Disability Certification form must be received by the Trust Fund Office within 12 months from the date of your disability. Forms filed after 12 months from the date of disability will not be accepted.

Becoming Eligible as a Retired Participant

Initial Eligibility

In order to become eligible as a Retired Participant, you must meet **all 4** of the following requirements:

1. You must be receiving a pension from the Cement Masons Pension Trust Fund for Northern California. If you are receiving a Pro-Rata or Partial Pension, the largest portion of your years of Credited Service **must be earned in Northern California;**
2. You must have been employed by an Individual Employer in the type of work requiring contributions to be made to the Cement Masons Health and Welfare Trust Fund for Northern California for at least 500 hours in the 12-month period immediately before the effective date of your pension from the Cement Masons Pension Trust Fund for Northern California. Disability Hour Credit granted to an Active Participant may be used to satisfy the 500-hour requirement;
3. You must be a member in good standing with your Cement Masons local union; **and**
4. You must make the required payments to the Fund in the amounts determined by the Board.

Grace Period. If you failed to satisfy the 500-hour requirement specified in #2 above due to disability, you may be entitled to a grace period. In order to be considered for the grace period, you must give written notice to the Board and submit written evidence of your disability, as determined by the Board. **A grace period may not exceed 3 years.**

If you meet **all of the requirements listed above**, your eligibility for benefits as a Retired Participant will begin on the later of the following dates:

1. On the first day of the month for which a pension is payable to you from the Cement Masons Pension Trust Fund for Northern California; **or**
2. The date on which your eligibility as an Active Participant terminates.



Caution: When you are first eligible to participate in the Plan as a Retired Participant and you decide not to enroll for benefits, you will not be given an opportunity in the future to enroll. Exception: See Special Enrollment Provision on pages 20-21.

Transitioning from Active Benefits to Retired Benefits

No Deductible amount or out-of-pocket cost that you have paid while covered as an Active Participant will be carried over to satisfy the Plan Year Deductible or Plan Year Out-of-Pocket Maximum described in this SPD if and when you become eligible as a Retired Participant. This rule will also apply to your eligible Dependents.

Termination of Eligibility

1. On the last day of the month in which a pension from the Cement Masons Pension Trust Fund for Northern California is no longer payable to you; **or**
2. During any month, prior to Normal Retirement Age (65) if you engage in:
 - a) Any employment covered by the Collective Bargaining Agreement (see Article I., Section 10.00 of the official Plan Rules and Regulations);
 - b) Any employment for the Northern California Joint Apprenticeship and Training Committee, the District Council or one of its affiliated local unions; **or**
 - c) Any employment or self-employment for wages or profits in the building and construction industry in the geographical jurisdiction of the Cement Masons Pension Trust Fund for Northern California, or a related Plan with which the Pension Fund has a reciprocal agreement; **or**
3. During any month after Normal Retirement Age (65) in which you are employed or self-employed for wages or profits for 40 or more hours during a calendar month in the state of California:

- a) In an industry in which employees were employed and accrued benefits under the Plan as a result of their employment at the time that the payment of benefits commenced or would have commenced had you not remained in or returned to employment; **and**
 - b) In a trade or craft in which you were employed at any time under the Plan; **or**
4. On the last day of the month preceding the month in which you fail to make the required payment to the Fund for your Retired Benefits. If you voluntarily terminate your participation in the Plan as a Retired Participant, you are required to provide a 60-day advance notice to the Trust Fund Office. If you terminate your participation, you **may** not be given the opportunity to enroll at a later date. **Exception:** See Special Enrollment Provisions on pages 20-21; **and**
 5. If you elect optional dental and/or vision coverage, you will be required to maintain that coverage for a minimum of 36 months. If you fail to make the required payment for optional dental and/or vision, your hospital-medical (including prescription Drug Benefits) will be terminated along with the dental and/or vision coverage.

Termination of Your Dependents Eligibility

1. The date your eligibility ends; or if earlier,
2. The date your Dependent no longer qualifies as a Dependent under the Plan.

Exception: Surviving Spouse Coverage

In the event of your death, your surviving spouse may continue coverage for herself and any eligible Dependent child or children until the first of the month following the earliest of the dates listed below:

1. The date your spouse remarries;
2. The date your spouse obtains other group health coverage;
3. The date the required premium payment is not made to the Cement Masons Health and Welfare Trust Fund; **or**
4. The death of your surviving spouse.

Special Enrollment Provision

In general, if you are eligible to enroll in the Plan as a Retired Participant and you choose not to enroll for Retired Benefits when they are first offered, you will not be given another opportunity. There are, however, exceptions under the **Special Enrollment Provision** of the Plan:

Acquiring a New Dependent. If you elected not to enroll for Retired Benefits when you were first eligible, and you subsequently acquire a new Dependent, i.e. a spouse or a Dependent child, you and

your eligible Dependents may enroll for Retired Benefits, however, you must do so **within 60 days** after acquiring the new Dependent. Contact the Trust Fund Office for further information.

If You Had Other Health Plan Coverage at the Time You Retired. If you elect not to enroll for Retired Benefits when you are first eligible because you have other health plan coverage, you may “defer” your enrollment in the Plan for Retired Benefits until you are no longer covered by the other health plan. You have **60 days** from the date the other health plan terminates to apply for enrollment in the Plan’s Retired Benefits. Contact the Trust Fund Office for further information.

Retired Participant Self-Payment Subsidy

The Board provides Retired Participants who meet the eligibility requirement below with a self-payment subsidy funded by Individual Employer contributions. The subsidy reduces the self-payment cost of purchasing the Fund’s hospital-medical benefits for Retired Participants.

The subsidy does not apply to self-payments for the Fund’s optional dental and/or vision plans nor does it apply to COBRA premiums if you elect COBRA Continuation Coverage.

The chart on the below explains the eligibility requirement and the percentage of subsidy for which you may qualify. The self-payment subsidy is based upon your years of Credited Service in the Cement Masons Pension Trust Fund for Northern California.

Retired Participant Self-Payment Subsidy Chart

Credited Service	The percent the Plan pays toward the self-payment costs for hospital-medical benefits	The percent the Retired Participant pays toward self-payment costs for hospital-medical benefits
If you have less than 10 Years of Credited Service under the Pension Plan	None	100%
You have at least 10 but less than 20 Years of Northern California Credited Service	20%	80%
You have at least 20 but less than 25 Years of Northern California Credited Service	30%	70%
You have 25 or more Years of Northern California Credited Service	40%	60%

New Eligible Packets for Active Cement Masons

When you first become eligible as an Active Participant, you are automatically enrolled in the Direct Payment Plan for hospital-medical benefits, which includes benefits for prescription Drugs, the self-funded Delta Dental Plan and the Vision Service Plan. You must, however, enroll your Dependents in the Plan by completing an Enrollment Form and supply certain documents.

After becoming eligible as an Active Participant, the Trust Fund Office will send you a “New Eligible Packet”. The packet contains an Enrollment Form, important information about the Fund’s hospital-medical and dental plan options available and the necessary forms if you wish to change from Direct Payment Plan to Kaiser Permanente Plan or from Delta Dental Plan to one of the optional dental plans.

If you have already completed and submitted an Enrollment Form to the Trust Fund Office and supplied the required documents to enroll your Dependents, you may wish to contact the Trust Fund Office to confirm that your Dependents are properly enrolled.

The New Eligible Packet includes the most recent “Comparison of Benefit Plans” for the Fund’s hospital-medical plan options and a Comparison of Dental Plans. The Comparisons are companion documents to this SPD and provide an overview of the Plan options. The Comparisons, however, do not replace this Summary Plan Description (SPD) nor the official Plan Rules and Regulations for the Direct Payment Plan, the Evidence of Coverage (EOC)/Disclosures for the Kaiser Permanente Plan or the summary of benefits, exclusions and limitations for the dental and vision plans.

Retired Participants. If you are eligible to participate in the Plan as a Retired Participant, shortly after receiving your final retirement papers from the Cement Masons Pension Trust Fund for Northern California, you will receive information about the Fund’s hospital-medical and dental plan options for Retired Participants. If you chose to enroll for benefits, you will be required to complete a new Enrollment Form, select a plan and make the required self-payment (generally, deducted from your monthly pension benefits). If you chose not to enroll at that time, you will not be given another opportunity. **Exception:** See Special Enrollment Provision on pages 20-21.

You should include Dependents on the Enrollment Form only if you want them to be enrolled in the Plan’s Retired Benefits. The self-payment cost to purchase the retired hospital-medical benefits and the optional dental and vision coverage is based upon whether you cover yourself only, yourself and your spouse or yourself, spouse and children and which plan options you select.

Self-payment costs are subject to change every January. If you are enrolled in a plan, you will receive a 30-day advance notice of any change to the self-payment amounts.

Enrolling Your Dependents Active and Retired Participants

Direct Payment and Kaiser Permanente Plan

Dependents Eligible to be Enrolled in the Plan

You may enroll the following Dependents:

- Your lawful spouse,
- Your children under the age of 26 if they are ¹:
 - Your natural born children;
 - Your stepchildren;
 - Your adopted children ²;
 - Foster children placed in your home ².
- Your children, upon reaching age 26, who are prevented from earning a living because of mental or physical handicap, may also be included in the Plan so long as the child was eligible under the Plan immediately prior to becoming age 26. In order for the coverage to be tax exempt, the Dependent child must be claimed on your income tax return for each Plan Year for which coverage is provided.
- The Plan will provide coverage for a Dependent child or children of an Active Participant if required by a Qualified Medical Child Support Orders (QMCSOs) as described in the Employee Retirement Income Security Act (ERISA) of 1974 section 609(a)(2)(A). The Plan will provide coverage for a Dependent child or children of a Retired Participant if required by a QMCSO if the Retired Participant makes the required self-payments to the Fund.

Footnote 1. Dependent children are covered until the end of the month in which they turn age 26.

Footnote 2. Adopted and foster children are covered on the date you become legally obligated to provide full or partial support for the child.

If you are a Retired Participant, there may be an additional cost to add a Dependent. Contact the Trust Fund Office for further information.

How to Enroll Your Dependents

Complete an Enrollment Form (see sample on page 25) and supply the required documents.

Documents Required to Enroll Dependents

For Spouse:

In order to complete the enrollment of a spouse, you must list your spouse on the Enrollment Form with her date of birth and her social security number and provide a certified copy of the marriage certificate.

For Children:

In order to complete the enrollment of Dependent children, you must list each child on the Enrollment Form with their date of birth and their social security number. You must also provide a copy of each child's certified birth certificate. Hospital issued certificates are not acceptable.

A Dependent child reaching the age of 26, is no longer eligible under the Plan as of the last day of the month in which the Dependent turns age 26, however, the child may, continue coverage under the Plan's COBRA Continuation Coverage for a temporary period of time (see "COBRA Continuation Coverage" beginning on page 27).

In order to complete the enrollment of a Dependent child who is adopted or who is placed in your home through a foster agency, you must list the child on the Enrollment Form with their date of birth and their social security number. You must also provide copies of the court documents as proof of the adoption. If the child you are enrolling is a foster child, you must provide copies of the placement documents from the foster care agency.

Any Dependent child who reaches age 26, is eligible under the Plan immediately prior to attaining age 26 and is prevented from earning a living due to mental or physical handicap may be entitled to continued coverage under your Plan while you remain eligible. To ensure continued coverage beyond age 26 for a handicapped or disabled Dependent child, you should request the necessary form from the Trust Fund Office prior to the Dependent's 26th birth date so coverage will not be interrupted.

As required by ERISA §609(a) (2) (A), the Plan will provide coverage for a Dependent child of an Active Participant upon receipt of a Qualified Medical Child Support Orders (QMCSO). The Plan will also provide coverage for the Dependent child of a Retired Participant if the Retired Participant makes the required self-payments to the Fund for that Dependent child.

Retired Participants. If you are enrolling in the Plan as a Retired Participant and you want to enroll your Dependents, more than likely the Trust Fund Office will already have the documents from when you were eligible as an Active Participant. When you complete the Enrollment Form as part of your retirement documents, list only those Dependents you want to enroll in the Plan for Retired Benefits. If those Dependents are the same as those enrolled in the Plan for Active Benefits, you will not be asked to again supply the required documents. However, if you acquire a new Dependent **after retirement** and wish to add that Dependent to the Plan, you will be required to supply the applicable document(s) depending upon whom you are enrolling. There may be an additional charge to add a new Dependent.

Below is the current Enrollment Form in use as of the printing of this SPD. Always check the Trust Funds' website for the most recent form.

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
CEMENT MASONS VACATION/HOLIDAY TRUST FUND FOR NORTHERN CALIFORNIA
CEMENT MASONS PENSION TRUST FUND FOR NORTHERN CALIFORNIA
 230 Campus Lane, Fairfield, CA 94514-1499 * Telephone: (707) 864-1398 or Toll Free at 1-888-245-5985
 E-Mail Address: customer-service@accal.comcastmasons.org * Website: http://www.aaccal.comcastmasons.org

ENROLLMENT FORM (Rev. 4/18)

Part I. PARTICIPANT INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER: _____ NAME: FIRST _____ MIDDLE _____ LAST _____

PHYSICAL ADDRESS: _____ CITY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (IF DIFFERENT FROM ABOVE): _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE: _____ E-MAIL ADDRESS, IF ANY: _____ LOCAL UNION NO.: _____ Cuando posible prefero recibir información de beneficios en Español.

CELL PHONE: _____

DATE OF BIRTH: MONTH / DAY / YEAR: ____ / ____ / ____ GENDER: MALE FEMALE PRESENT MARITAL STATUS: NEVER MARRIED SINGLE MARRIED -- (date of marriage) -- / / PRIOR MARRIAGE (if applicable): name of ex-spouse: _____ date of divorce: _____

Part II. DEPENDENT INFORMATION *If dependents have different address than you, attach separate sheet with their addresses

IMPORTANT: Add new or delete previously enrolled "Dependents" below. The term "Dependents" means your legal spouse, your children under age 26 regardless of marital status, and your unmarried children age 26 or older who are totally handicapped as explained in the Plan. Unless documents have been previously provided, you are required to mail the applicable document(s) below to the Trust Fund Office to substantiate your relationship to your dependent(s).

SPOUSE - Marriage Certificate * If you are divorced, you must provide copy of the Final Decree of Marriage. Your ex-spouse will lose dependent status as of the date of dissolution.

DOMESTIC PARTNER - Read Part III below

NATURAL/STEP-ADOPTED CHILD - Birth Certificate and legal adoption document for adopted child

LEGAL GUARDIANSHIP - Guardianship papers or documents from a Court appointing you as the legal guardian

FOSTER CHILD - Proof of foster child placement or custody from a placement agency or a Court appointing you as the foster parent. Print your Social Security number on each of the document(s) for identification purposes.

Add/Delete	Relationship	Gender	Name (Fav. M, Last)	Date of Birth Month Day Year	Social Security No.
<input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Spouse, or <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	- -
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	- -
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	- -
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	- -

* You will be responsible for any incorrectly paid claims resulting from your failure to notify the Trust Fund Office of changes in dependent status, such as, but not limited to, death, divorce, or loss of legal guardianship.
 * This form will be returned if you fail to provide the dependent's date of birth and Social Security number.

Part III. DOMESTIC PARTNER HEALTH AND WELFARE PLAN'S ELIGIBILITY

In order to determine whether your Domestic Partner meets your Health and Welfare Plan's requirement for Domestic Partner coverage, please furnish the information below. To enroll your Domestic Partner's children, if any, you must provide the applicable documents as listed in the Dependent Information section of this form.

A written statement from your employer certifying that the employee 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. If the employer has entered into a contract with the State of California, they must also certify that the contract is in effect for a period of 180 days or more during the State's fiscal year.

If your employer certifies that they have entered into a job contract with the City or County of San Francisco, City of Oakland or City of Sacramento, you must provide a copy of your Domestic Partner certificate issued by any city, county or state agency.

If your employer certifies that they have entered into a job contract with the County of San Mateo or the State of California, you and your partner must be registered as domestic partners with the California Secretary of State, obtain a domestic partners certificate from the Secretary of State's office and provide a copy to the Trust Fund Office.

Revised 3/23/2015

Part IV. OTHER INSURANCE COVERAGE INFORMATION

Do any of your dependents listed on the reverse side of this form have another employer-sponsored medical, prescription drug, dental and/or vision Plan coverage either as an employee or as a dependent?

No -- Skip this section. **NOTE:** You must notify the Trust Fund Office immediately if any dependent obtains other insurance for any reason, such as entitlement to Medicare, Medi-Cal, disability, or through employment.

Yes -- Fill in section IV. If the other insurance applies to all dependents listed on the front side of this form, complete the box below. If one or more of your dependents have more than one other insurance, make a photocopy of this section and complete for each dependent.

Do(es) the dependent(s) live with you?
 Yes No -- If 'No' with whom does the child live? Name: _____ Relationship: _____
 * If you are divorced, provide copy of any court orders pertaining to custody and/or health coverage for the dependent

Name(s) of dependent(s) covered by other insurance: _____

Name of insured or policy holder: _____ Relationship to Participant: _____

Social Security number or ID number of insured: _____ Name of employer providing the coverage: _____

TYPE OF BENEFITS PROVIDED	POLICY NUMBER	EFFECTIVE DATE	DEPENDENTS COVERED?
NAME & ADDRESS OF MEDICAL PLAN			<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME & ADDRESS OF DENTAL PLAN			<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME & ADDRESS OF PRESCRIPTION DRUG PLAN			<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME & ADDRESS OF VISION CARE PLAN			<input type="checkbox"/> YES <input type="checkbox"/> NO

Part V. BENEFICIARY INFORMATION - DESIGNATION OF BENEFICIARY

1. **Health and Welfare and Vacation/Holiday Trust Funds** - You may designate any beneficiary you wish. Any benefits due from these Funds will be paid to your named beneficiary.

2. **Pension Trust Fund** - If you are married, any benefits due will be paid to your surviving spouse, and not to your named beneficiary if not your spouse, in accordance with the provisions of the Pension Plan. Contact the Trust Fund Office as early as possible to complete the necessary forms for your Pension Plan. Contact the Trust Fund Office as early as possible to complete the necessary forms for your Pension Plan.

Check here if you want to designate more than one person for one or more of the Funds. The necessary forms will be mailed to you.

Check here if you do not want to change your previously designated beneficiary.

* If you do not designate a beneficiary below (and also do not check the box above), any death benefits payable will be paid equally to one or more of your surviving relatives as this Enrollment Form replaces the form you have previously filed, if any, and will be effective upon receipt by the Trust Fund Office.

SOCIAL SECURITY NUMBER: _____ NAME: FIRST _____ MIDDLE _____ LAST _____ RELATIONSHIP _____

MAILING ADDRESS: _____ CITY _____ STATE _____ ZIP CODE _____

*** Please do not list 'self' as your beneficiary ***

PARTICIPANT STATEMENT - You MUST date and sign form

I hereby certify under penalty of perjury under the laws of the State of California that the information given in this form is true, correct and complete to the best of my knowledge.

DATE: _____ SIGNATURE: _____

If You Divorce

As of the date your divorce becomes final, your former spouse along with any stepchildren, if applicable, are no longer eligible Dependents under the Plan. As soon as you know this date, you must act immediately.

Complete a new Enrollment Form and delete all ineligible individuals. Send the new Enrollment Form to the Trust Fund Office with a copy of your final Judgment of Dissolution terminating your marriage. You should follow-up with the Trust Fund Office within 15 business days from the date you mail these documents to the Trust Fund Office to make sure that they arrived and the individuals you asked to be removed have actually been removed from coverage. A divorce is a COBRA Qualifying Event for your former spouse (and any stepchildren, if applicable). See "COBRA Continuation Coverage" beginning on page 27.

Your Enrollment Responsibility

It is your responsibility to keep your enrollment information current including adding and deleting Dependents, as in the case of a divorce (deleting) or a newborn child (adding). These changes must be made in writing. The eligibility of Dependents cannot be changed over the telephone.

CAUTION

If you do not remove your former spouse, including any stepchildren, if applicable, from the Plan as of the date your divorce is final and the Fund pays any Claims for services on or after that date for your former spouse or stepchildren, you will be responsible for repaying the Fund the amount of the benefits paid on behalf of those ineligible individuals.

Change of Address Notification

Direct Payment and Kaiser Permanente Plan

The Trust Fund Office cannot accept a change of address over the telephone.

Below is the current Change of Address Notification form in use as of the printing of this SPD. Always check the Trust Funds' website for the most recent form.

If you need to make changes to the initial contact information shown on your Enrollment Form, you should do so by submitting a "Change of Address Notification", form—see sample to the right. You can print this form from the Funds' website (the fastest way). If you have Dependents who live at an address separate from yours, use a separate piece of paper and write down their name, birth date, social security number and mailing address and attach it to the "Change of Address Notification" form.

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
CEMENT MASONS VACATION/HOLIDAY TRUST FUND FOR NORTHERN CALIFORNIA
CEMENT MASONS PENSION TRUST FUND FOR NORTHERN CALIFORNIA
220 Campus Lane, Fairfield, CA 94534-1499 * Telephone: (707) 864-3309 or Toll-Free at 1-888-245-5865
E-Mail Address: customerservice@norcalcementmasons.org * Website: http://www.norcalcementmasons.org

CHANGE OF ADDRESS NOTIFICATION (Doc. 410)

PARTICIPANT INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST	MIDDLE	LAST
HOME PHONE	LOCAL UNION NO.	E-MAIL ADDRESS, IF ANY	
CELL PHONE			

NEW ADDRESS

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
INDICATE DATE YOU WANT THE FUND OFFICE TO USE YOUR NEW ADDRESS: MONTH / DAY / YEAR			

OLD ADDRESS

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

PARTICIPANT SIGNATURE

DATE:	SIGNATURE:
-------	------------

IMPORTANT

This Change of Address form is to be used for changing your address record with the Fund Office only. Submitting this form will not change your address with your Local Union. You should contact your Local Union directly to change your address record with them.

You must complete an ENROLLMENT FORM if you want to change dependent status and/or beneficiary.
Check-off this box to receive an ENROLLMENT FORM.

Revised 10/1/2013

No change will be made to your contact information until the required written notice is received by the Trust Fund Office.

What Happens When Eligibility under the Plan Ends?

Consolidated Omnibus Budget Reconciliation Act **COBRA Continuation Coverage** Direct Payment and Kaiser Permanente Plan

The Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law enacted in 1986, requires that when eligibility under the Plan ends, certain Qualifying Events permit a Qualified Beneficiary to continue health plan coverage for a temporary period of time and is dependent on the reason eligibility was lost. The type of Qualifying Event determines the duration of COBRA Continuation Coverage available.

Qualified Beneficiary

A Qualified Beneficiary is any individual who was eligible for hospital-medical benefits (Direct Payment or Kaiser Permanente Plan) on the day before a Qualifying Event occurred.

Qualifying Events

If any of the Qualifying Events listed below occurs, a Qualified Beneficiary has the right to continue the health plan benefits that were in effect on the day before the Qualifying Event occurred. To continue coverage, the Qualified Beneficiary must apply for COBRA Continuation Coverage and make the required monthly payments to the Fund within the specified time frames.

Active Benefits: The following are Qualifying Events:

1. Work hours reported on your behalf by an Individual Employer are less than the required monthly minimum for continued eligibility;
2. Your death;
3. Your divorce or legal separation from your Dependent spouse;
4. Your child loses status as a Dependent under the Plan.

Retired Benefits: The following are Qualified Events:

1. Your death;
2. Your divorce or legal separation from your Dependent spouse;
3. Your child loses status as a Dependent under the Plan.

Duration of COBRA Continuation Coverage

If you or your Dependents qualify for COBRA Continuation Coverage, you or your Dependents can elect coverage for up to 18, 29, or 36 months, depending on the Qualifying Event:

- **18 Months**—A Qualified Beneficiary, can continue coverage for up to 18 months from the date of the Qualifying Event if the Qualifying Event was because an Individual Employer ceased to make contributions to the Fund on your behalf causing loss of eligibility under the Plan.

- **29 Months**— Any Qualified Beneficiary can extend the 18-month period by 11 months, for a total of 29 months, if the Qualified Beneficiary becomes disabled, as determined by the Social Security Administration, before or during the first 60 days of COBRA Continuation Coverage. See “Timely Notice to the Trust Fund Office” on page 30.
- **36 Months**—Qualifying Events 2, 3 and 4 for Active Benefits and 1, 2 and 3 for Retired Benefits entitle your Dependents to up to 36 months of COBRA Continuation Coverage from the date of the Qualifying Event. (In the case of a child’s losing Dependent status, only the affected child is eligible for 36 months of coverage.)

Extending COBRA Continuation Coverage in Cases of Disability

If a Qualified Beneficiary becomes totally disabled before or during the first 60 days of COBRA Continuation Coverage, COBRA may be extended for an additional 11 months, for a total of 29 months. To qualify for the extension, the Qualified Beneficiary must be considered totally disabled by the Social Security Administration. All family members of the disabled individual are entitled to the additional 11-month extension of COBRA. See “Timely Notice to the Trust Fund Office” on page 30.

NOTE: The cost for the additional 11 months of COBRA Continuation Coverage will be approximately 50% higher than the cost charged during the first 18-months of COBRA Continuation Coverage.

Extending COBRA Continuation Coverage When a Second Qualifying Event Occurs

If, during the 18-month period of COBRA Continuation Coverage, the Active Participant dies, divorces or a Dependent child loses his Dependent status under the Plan, the maximum period of COBRA Continuation Coverage for the Active Participant’s spouse and Dependent children can be extended to 36 months **from the date of the initial Qualifying Event**.

Effect of Medicare Entitlement before a Termination of Employment or Reduction in Hours

If you are an Active Participant and the reporting of insufficient work hours occurs less than 18 months after the date you became entitled to Medicare (Part A, Part B, or both), the maximum period of COBRA Continuation Coverage for your Dependents will be 36 months from the date of your Medicare entitlement.

As an illustration:

- Your **Q**ualifying **E**vent (QE) is January 1, 2015 (based upon a reduction in hours).
- You were entitled to Medicare on June 1, 2014 (6 months before the QE).
- You are entitled to COBRA Continuation Coverage for 18 months from January 1, 2015.
- Your Dependents are entitled to 36 months of COBRA Continuation Coverage from June 1, 2014 (your Medicare entitlement date) or 30 months from the QE (36 less 6 months).

Effect of Medicare Entitlement after a Termination of Employment or Reduction in Hours

Medicare entitlement is not a Qualifying Event under this Plan. Medicare entitlement after a termination of employment or the reporting of insufficient hours will not extend a Qualified Beneficiary's COBRA coverage beyond 18 months.

As an illustration:

- Your Qualifying Event is January 1, 2015 (based upon a reduction in hours).
- You are entitled to Medicare on June 1, 2015 (6 months after your QE).
- Your COBRA Continuation Coverage ends on June 1, 2015 (the date of your Medicare entitlement).
- Your Dependents can continue COBRA for the full 18 months from January 1, 2015.

Benefits Available under COBRA Continuation Coverage

A Qualified Beneficiary may elect hospital-medical (including prescription Drug) benefits only, this is called "Core Coverage", or may elect Core Coverage and include dental and vision benefits and is called "Core Plus Coverage". Dental and vision benefits are not available alone without hospital-medical benefits.

COBRA Continuation Coverage Options

Core Coverage	Core Plus Coverage
Hospital-medical (including prescription Drugs) benefits.	Hospital-medical (including prescription Drugs), benefits and dental and vision.
Death and Accidental Death and Dismemberment benefits are not available under COBRA Continuation Coverage.	

Duty to Notify the Trust Fund Office

If you are an Active Participant, the Trust Fund Office will know when you lose eligibility under the Plan as a result of a reduction in work hours. The Trust Fund Office will also know, for an Active or Retired Participant, when an enrolled Dependent child has reached age 26 and is no longer an eligible Dependent under the Plan. You do not need to provide notice to the Trust Fund Office of these Qualifying Events.

However, it is the Qualified Beneficiary's responsibility to provide timely written notice to the Trust Fund Office of any of the following Qualifying Events:

1. Your divorce or legal separation;
2. Your death;
3. Your handicapped child over the age of 26 loses Dependent status under the Plan;

4. The occurrence of a second Qualifying Event while your Dependents are in an 18-month COBRA Continuation period (see “Extending COBRA Coverage When a Second Qualifying Event Occurs” on page 28);
5. You or your Dependent have a Qualifying Event that entitles you to COBRA Continuation Coverage with a maximum duration of 18 months and the Social Security Administration determines that one of you is disabled; or
6. The Social Security Administration determines that the individual is no longer disabled.

Notice from one Qualified Beneficiary will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event. For example, if your spouse notifies the Trust Fund Office that your handicapped child no longer meets the definition of “Dependent” under the Plan, the single notice would satisfy the notice requirements.

Timely Notice to the Trust Fund Office

If the notice that is being provided is of a divorce or legal separation, a handicapped Dependent child over the age of 26 losing eligibility, or a second Qualifying Event, you or a Qualified Beneficiary must provide written notice to the Trust Fund Office, no later than 60 days after the date of the Qualifying Event.

If notice is being provided in order to qualify for the additional 11 months of COBRA due to disability (see “Extending COBRA Continuation Coverage in Cases of Disability” on page 28), the Qualified Beneficiary must report the Social Security disability determination to the Trust Fund Office before the end of the original 18 month COBRA period **and** provide a copy of the Social Security Administration disability determination letter within 60 days from the date on the determination letter.

If notice is being provided about a Social Security Administration determination that the Qualified Beneficiary is no longer disabled, written notice must be provided to the Trust Fund Office no later than 30 days from the date of the Social Security Administration determination that the person is no longer disabled.

If a Qualified Beneficiary does not notify the Trust Fund Office within the time frames listed under “Timely Notice to the Trust Fund Office”, the Qualified Beneficiary will lose his COBRA rights.

How to Notify the Trust Fund Office

When a Qualified Beneficiary provides timely notice, **in writing**, to the Trust Fund Office of any of the Qualifying Events listed on page 27, the notice must include:

- The name of the Qualified Beneficiary;
- The Participant’s name and Health Plan Identification number or Social Security number;
- The event for which notice is being provided and the date of the Qualifying Event (for example, the date a handicapped Dependent child is losing Dependent status as a

handicapped child, the Participant's death, or the date of divorce or legal separation, etc.);
and

- A copy of the final judgment of dissolution of marriage if the Qualifying Event is a divorce or a copy of the court order confirming a legal separation from your Dependent spouse.

Trust Fund Office Staff is Available to Help!

Preserve your COBRA rights: If you have questions about how to or when to notify the Trust Fund Office of a Qualifying Event or you just need help understanding COBRA Continuation Coverage, call the Trust Fund Office 1 888 245 5005 (within California) or 1 707 864 3300 (all other locations) and choose the option for the COBRA department.

Where to Send Your Notice of a Qualifying Event

Notice of a Qualifying Event should be sent to the Trust Fund Office at the following address:

**Cement Masons Health and Welfare Trust Fund for Northern California
Attn: COBRA Department
220 Campus Lane | Fairfield, California 94534-1499**

Electing COBRA Continuation Coverage

After receiving notice of a Qualifying Event, the Trust Fund Office will send the Qualified Beneficiary a notice of his/her right to choose COBRA Continuation Coverage, along with an **Election Form**. If you or your Dependents do not qualify for COBRA Continuation Coverage, a Notice of "Unavailability of COBRA Continuation Coverage" will be sent. These notices will be sent within 14 days from the date the Trust Fund Office receives notice of a Qualifying Event. It is very important that you keep your address and that of your Dependent(s), if they live at an address other than yours, current so the Trust Fund Office can communicate with you and your Dependents.

The Qualified Beneficiary must sign, date and return the **Election Form** to the Trust Fund Office no later than 60 days after the date eligibility is lost or the date the Qualified Beneficiary receives the COBRA notice from the Trust Fund Office, whichever is later or the Qualified Beneficiary will not be eligible for COBRA Continuation Coverage. If the Qualified Beneficiary does not file the **COBRA Election Form** within this 60-day period, the Qualified Beneficiary will lose rights to COBRA Continuation Coverage.

If you do not choose COBRA Continuation Coverage for yourself, your health insurance coverage will end. However, your spouse and eligible Dependents may elect COBRA Continuation Coverage regardless of your decision.

Cost of COBRA Continuation Coverage

COBRA Continuation Coverage is only available at your own expense.

The cost of COBRA Continuation Coverage will be outlined in the Notice of Entitlement to COBRA Continuation Coverage. If a Qualified Beneficiary elects COBRA Continuation Coverage, the full cost

of the benefit plan, plus a 2% administrative fee will be charged (in the case of the 11 month extension due to a disability, the charge is the full cost of the benefit plan plus 50%). This cost is subject to future increases during the COBRA Continuation Coverage period. If the cost changes, the Trust Fund Office will revise the charge a Qualified Beneficiary is required to pay and send a notice 30 days prior to the change. In addition, if the benefits change under the Plan, the benefits under COBRA Continuation Coverage will change as well.

Paying for COBRA Continuation Coverage

There is an initial grace period of **45 days** from the date COBRA Continuation Coverage was elected, to pay the first COBRA premium.

If the first premium payment is not made when due, COBRA Continuation Coverage will not take effect. After the first payment, subsequent payments are due on the first day of the month for which coverage is provided. There is a grace period of **30 days** to pay the monthly premium. If the Qualified Beneficiary does not pay the premium by the end of the grace period, COBRA Continuation Coverage will terminate. **IMPORTANT:** Making the payment during the grace period may affect eligibility during the grace period. The payment must be made before eligibility can be confirmed should any health care provider inquire with the Trust Fund Office as to the eligibility status of a Qualified Beneficiary.

The first COBRA payment must cover the period from the date coverage terminated under the Plan up to the current month's coverage. For example, if coverage terminated on September 30, 2015 and the Qualified Beneficiary returns the **Election Form** so that it is received by the Fund no later than November 29, 2015 (within 60 days from the loss of eligibility), the first payment is due no later than January 13, 2016 (within 45 days of the November 29th election). This payment must include COBRA premiums for October, November and December 2015. In addition, the payment for January 2016 coverage must be received no later than January 30, 2016 which is the end of the grace period.

Adding New Dependents under COBRA Continuation Coverage

If, while enrolled for COBRA Continuation Coverage, a Qualified Beneficiary acquires a new Dependent he may enroll the new Dependent for coverage for the balance of the period of COBRA Continuation Coverage. However, the enrollment of a new Dependent must occur **within 30 days** from the date that the Qualified Beneficiary acquires the new Dependent. Adding a new Dependent may cause an increase in the amount that must be paid for COBRA Continuation Coverage.

While any Qualified Beneficiary can add a new Dependent to his COBRA Continuation Coverage, the only newly added family members who have the rights of a Qualified Beneficiary to extend COBRA if a second Qualifying Event occurs and are Dependents **of the former Participant**.

Special Enrollment for the Balance of Your COBRA Continuation Period: If you have an eligible Dependent who did not enroll for COBRA Continuation Coverage when it was first offered because they had other health plan coverage and that coverage is subsequently lost, you may enroll that Dependent for the remainder of your COBRA Continuation period. For this to occur:

- Your Dependent must have been eligible for COBRA Continuation Coverage on the date of the Qualifying Event but declined when enrollment was offered because he had coverage under another group health plan or had other health insurance coverage;

- Your Dependent must exhaust his other coverage, lose eligibility for it, or lose employer contributions to it, **and**
- You must enroll that Dependent by sending an Enrollment Form to the Trust Fund Office **within 30 days** after the termination of other coverage or contributions.

Changing Hospital-Medical Plans under COBRA Continuation Coverage

If a Qualified Beneficiary wishes to change hospital-medical plans, he may do so up to twice in a calendar year. To change a plan while enrolled in COBRA, the Qualified Beneficiary should contact the Trust Fund Office for a Plan Application Form; the application is also available on the Funds' website. Complete and submit the application to the Trust Fund Office. Once the application has been processed by the Trust Fund Office, the Qualified Beneficiary will be notified in writing, confirming the plan and the effective date of the change.

Changing Dental Plans under COBRA Continuation Coverage

If a Qualified Beneficiary selected the CORE Plus Coverage when first enrolled for COBRA, he can change that dental plan only during Open Enrollment (OE) which is October through December 15th each year for a January 1st effective date.

A Qualified Beneficiary should not assume his hospital-medical and/or dental plan has been changed until a written confirmation has been received from the Trust Fund Office.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate at the end of the maximum continuation period allowed (18, 29, or 36 months). COBRA Continuation Coverage will terminate before the end of the 18, 29, or 36 month period if one of the following events occurs:

1. The Qualified Beneficiary fails to pay the required premium payments in full and on time;
2. The Qualified Beneficiary becomes covered under another group health plan after the date he elected COBRA Continuation Coverage;
3. The Qualified Beneficiary becomes entitled to Medicare Part A or Part B after the date of his COBRA election;
4. Your employer no longer provides group health coverage to any of its Employees; **or**
5. The Qualified Beneficiary has received a final determination from the Social Security Administration that the Qualified Beneficiary is no longer disabled.

COBRA Continuation Coverage will terminate on the first day of the month following any of the events listed above. The Trust Fund Office will send you a written notice as soon as practicable following a decision that continuation coverage has or will terminate.

IMPORTANT: Keep your enrollment information and contact information that is on file at the Trust Fund Office current. If you have changed marital status, or you or your spouse or other Dependents have changed addresses, contact the Trust Fund Office immediately. Notify the Trust Fund Office of any Qualifying Event, even if your Employer is required to give notice to the Trust Fund Office.

Should federal or state law alter the provisions of COBRA in existence after the time this Summary Plan Description (SPD) is printed, Participants will be advised of these modifications, as required.

ACA Health Insurance Marketplace

If you or an eligible Dependent lose eligibility under the Plan, in addition to COBRA Continuation Coverage offered through the Fund, you may also have other health plan choices available to you through the ACA Health Insurance Marketplace. If you are a California resident, contact: **www.coveredca.com**. If you live elsewhere in the United States, contact: **www.healthcare.gov**.

Choice of Hospital-Medical Plans

Both hospital-medical plan options (the Direct Payment and Kaiser Permanente Plans) provide coverage for no-cost Preventive Care Services mandated by the new health care law.

Under the Direct Payment Plan, “no cost” applies only when you obtain covered Preventive Care Services from a Participating Provider that is part of the Fund’s Preferred Provider Plan network or from a pharmacy that contracts with the Fund’s Pharmacy Benefit Manager (PBM), OptumRx. If you select the Kaiser Permanente Plan as your plan of choice, “no-cost” only applies when you obtain covered Preventive Care Services from a Kaiser Permanente Plan facility in Northern California. For a complete list of no-cost Preventive Care Services, visit this website: www.healthcare.gov/preventive-care-benefits.

Hospital-Medical Plan Options

1. Direct Payment Plan. You are automatically enrolled in this plan upon establishing your initial eligibility as an Active Participant; **or**
2. Kaiser Permanente Plan provided you live in a Northern California Kaiser Permanente service area.

This SPD primarily describes the hospital-medical (including prescription Drug) benefits and provisions under the Direct Payment Plan. Read each section in this SPD carefully to see whether it applies only to the Direct Payment Plan or it includes Kaiser Permanente Plan.

If you are considering Kaiser Permanente Plan as your hospital-medical plan of choice, there is a separate “Evidence of Coverage” (EOC)/Disclosures booklet explaining the benefits, limitations and exclusions of the Kaiser Permanente Plan. If you would like more information about the Kaiser Permanente Plan **before** you consider a plan change, call the Trust Fund Office to request a Kaiser Permanente Plan booklet. Otherwise a Kaiser Permanente Plan booklet will automatically be sent to you shortly after your application for a plan change has been received and processed by the Trust Fund Office. If you have questions about the Kaiser Permanente Plan, you can also call Kaiser Permanente directly—the Fund’s Kaiser Plan group number is “500”.

You should carefully review the Comparison of Benefit Plans, this SPD, and if needed, the official Plan Rules and Regulations and the Kaiser Permanente EOC to see which hospital-medical plan will meet the health care needs of you and your eligible Dependents.

If you decide to change plans, you must complete a Plan Application Form.

If you are a Retired Participant or the Dependent of a Retired Participant who is Eligible for Medicare and you have selected the Kaiser Permanente Plan, in addition to the Cement Masons Retired Plan Application Form, you must also complete a Kaiser Permanente Senior Advantage (KPSA) Election Form. By signing the KPSA Election Form, you are assigning your right to Medicare benefits to Kaiser Permanente—this type of plan is called a “Medicare Advantage” plan or Medicare Part “C”. If you later change to the Direct Payment Plan or you select another health plan outside of the Fund, you must complete a KPSA Disenrollment Form to release your Medicare benefits from Kaiser Permanente.

Below are the current Active and Retired Plan Application Forms in use as of the printing of this SPD.

Always check the Funds' website for the most recent forms

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
 220 Campus Lane, Fairfield, CA 94534-1499
 Telephone: (707) 864-3300 or Toll-Free at 1-888-245-6005
 E-Mail Address: customerservice@norcalcementmasons.org
 Website: http://www.norcalcementmasons.org

FUND OFFICE USE ONLY (536)
 EFF. DATE: _____
 HOID: **CM**
 ELIGIBILITY CODE/GROUP NO.: _____

ACTIVE PLAN APPLICATION FORM

PARTICIPANT INFORMATION (Please print or type in black ink only)

SOCIAL SECURITY NUMBER: _____ NAME: FIRST _____ MIDDLE _____ LAST _____
 RESIDENCE ADDRESS (not Post Office Box) _____ CITY _____ STATE _____ ZIP CODE _____
 TELEPHONE NO. _____ LOCAL UNION _____ DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____ GENDER: MALE FEMALE
 MARITAL STATUS: SINGLE MARRIED

BENEFIT HEALTH PLAN OPTIONS You & your Dependents must be enrolled in the **same** Benefit Health Plan.
 CEMENT MASONS DIRECT PAYMENT PLAN
 KAISER PERMANENTE IF NOW OR A FORMER KAISER MEMBER, ENTER MEDICAL RECORD #: _____

DEPENDENT INFORMATION (List all eligible dependents; use reverse side if you need more space)

RELATIONSHIP	GENDER	FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM PARTICIPANT)	DATE OF BIRTH (MO / DY / YR)	SOCIAL SECURITY NUMBER	IF NOW OR PREVIOUSLY KAISER MEMBER, ENTER MEDICAL RECORD #
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				

I apply for health plan membership. I certify under penalty of perjury, under the laws of California that the information given in this form is true, correct, and complete to the best of my knowledge.

I UNDERSTAND THAT EXCEPT FOR SMALL CLAIMS COURT CASES, CLAIMS SUBJECT TO THE MEDICARE APPEALS PROCEDURE, OR BENEFIT-RELATED DISPUTES IN COMPLIANCE WITH ERISA, ANY CLAIM THAT I, MY HEIRS, OR OTHER CLAIMANTS ASSOCIATED WITH ME, ASSERT FOR ALLEGED VIOLATION OF ANY DUTY ARISING OUT OF OR RELATING TO MALPRACTICE, FOR PREMISES LIABILITY, OR RELATING TO THE COVERAGE FOR OR DELIVERY OF SERVICES, OR ITEMS, IRRESPECTIVE OF LEGAL THEORY, MUST BE DECIDED BY BINDING ARBITRATION UNDER CALIFORNIA LAW AND NOT BY A LAWSUIT OR COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. I UNDERSTAND THAT THE FULL ARBITRATION PROVISION IS CONTAINED IN THE EVIDENCE OF COVERAGE (EOC). I AGREE TO GIVE UP MY RIGHT TO A JURY TRIAL AND ACCEPT THE USE OF BINDING ARBITRATION. Your application will not be accepted without your signature below.

Date: _____ Participant's Signature: _____

FUND OFFICE USE ONLY (Please do not write in this space)

NEW PARTICIPANT OPEN ENROLLMENT NEW DEPENDENT
 COBRA - DATE OF QUALIFYING EVENT: _____ DATE: _____ BY: _____

REMARKS: _____
 DATE: _____ BY: _____

Revised 2/28/2015

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
 220 Campus Lane, Fairfield, CA 94534-1499
 Telephone: (707) 864-3300 or Toll-Free at 1-888-245-6005
 E-Mail Address: customerservice@norcalcementmasons.org
 Website: http://www.norcalcementmasons.org

FUND OFFICE USE ONLY (640)
 EFF. DATE: _____
 HOID: **CM**
 ELIGIBILITY CODE/GROUP NO.: _____

RETIRED PLAN APPLICATION FORM

RETIREE INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER: _____ NAME: FIRST _____ MIDDLE _____ LAST _____
 RESIDENCE ADDRESS (not Post Office Box) _____ CITY _____ STATE _____ ZIP CODE _____
 TELEPHONE NUMBER _____ LOCAL UNION _____ DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____ SEX: MALE FEMALE
 MARITAL STATUS: SINGLE MARRIED

ARE YOU ENROLLING AS A BENEFICIARY OF A DECEASED RETIREE? NO
 YES: PROVIDE THE DECEASED RETIREE'S SOCIAL SECURITY NUMBER: _____

DEPENDENT INFORMATION (List all eligible dependents to be enrolled)

RELATIONSHIP	GENDER	FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM RETIREE)	DATE OF BIRTH (MO / DY / YR)	SOCIAL SECURITY NUMBER	Kaiser Medical Record Number (see " below)
<input type="checkbox"/> SPOUSE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
<input type="checkbox"/> CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				

** Kaiser Medical Record Number - If you selected a Kaiser Plan and any of your dependents listed above is currently or formerly a Kaiser member, write the Medical Record Number, if known, for each dependent and write YOUR Kaiser Medical Record Number here ->

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER INSURANCE? NO
 YES: PROVIDE NAME OF THE INSURANCE COMPANY: _____

PLAN OPTIONS FOR INDIVIDUALS WHO ARE NOT ELIGIBLE FOR MEDICARE Check only one box.

A Kaiser Permanente
 B Cement Masons Direct Payment Plan

Revised: 2/27/2015 -- Please complete both sides of this form --

When You Can Change Hospital-Medical Plans

You are free to change your hospital-medical plan up to two times in a calendar year.

CAUTION: Any Plan Year Deductible satisfied or cost sharing expenses applied under one plan will not count towards the Deductible and/or cost sharing limits of the new plan.

Before you change plans, you may want to consider making your plan change effective with the beginning of a new Plan Year. This means that any Plan Application Form would need to be at the Trust Fund Office no later than December 15th for a January 1st effective date for the change. Once your Plan Application Form has been processed by the Trust Fund Office, you will be notified **in writing**, confirming the plan and the effective date of the change.

Do not assume your hospital-medical plan has changed until you receive a letter from the Trust Fund Office confirming the effective date of your new plan.

PLAN OPTIONS FOR MEDICARE-ELIGIBLE INDIVIDUALS Check only one box.

Please read the following important notice before making an election. The Plan's term "Eligible for Medicare" means an individual who is qualified to enroll in both Federal Medicare Parts A and B and **actually** or **not** the individual has actually enrolled for Medicare. If you are an "Eligible for Medicare" individual who did not enroll in both Medicare Parts A and B:

(1) You cannot elect Kaiser below as they require the individual to be enrolled in both Parts A and B.
 (2) If you elect the Cement Masons Direct Payment Plan, the Plan will charge you the Medicare premium rate whether or not you enrolled in Medicare Part B, and, will estimate the benefits payable under Medicare when your claims are paid.

After you file this application, it is your obligation to notify the Fund Office immediately of any changes to your Medicare enrollment status. Please answer the following questions and make your Plan election below:

YOUR Medicare effective date: PART A: MONTH: _____ YEAR: _____ PART B: MONTH: _____ YEAR: _____ PART D: MONTH: _____ YEAR: _____

Your SPOUSE Medicare effective date: PART A: MONTH: _____ YEAR: _____ PART B: MONTH: _____ YEAR: _____ PART D: MONTH: _____ YEAR: _____

IMPORTANT
 You and your eligible dependents must be enrolled with the same Plan. For example, if you have Medicare and elected Kaiser's Senior Advantage (box C below) and your spouse is Non-Medicare, she must elect Kaiser Permanente (box A on front page). Your spouse cannot elect the Cement Masons Direct Payment Plan (box B).

A copy of your Medicare Card (with Parts A & B) is required. If both you and your Spouse are eligible for Medicare, YOU MUST ENROLL IN THE SAME PLAN by checking box C or D below.

C Kaiser Permanente Senior Advantage Plan
 If you elect Kaiser Senior Advantage Plan, you must also complete their application form for each person enrolling in Kaiser Senior Advantage Plan and mail all the applications to the Trust Fund Office - do NOT mail the applications to Kaiser Permanente.

D Cement Masons Direct Payment Plan

I apply for health plan membership. I certify under penalty of perjury, under the laws of California that the information given in this form is true, correct, and complete to the best of my knowledge. I UNDERSTAND THAT EXCEPT FOR SMALL CLAIMS COURT CASES, CLAIMS SUBJECT TO THE MEDICARE APPEALS PROCEDURE, OR BENEFIT-RELATED DISPUTES IN COMPLIANCE WITH ERISA, ANY CLAIM THAT I, MY HEIRS, OR OTHER CLAIMANTS ASSOCIATED WITH ME, ASSERT FOR ALLEGED VIOLATION OF ANY DUTY ARISING OUT OF OR RELATING TO MALPRACTICE, FOR PREMISES LIABILITY, OR RELATING TO THE COVERAGE FOR OR DELIVERY OF SERVICES, OR ITEMS, IRRESPECTIVE OF LEGAL THEORY, MUST BE DECIDED BY BINDING ARBITRATION UNDER CALIFORNIA LAW AND NOT BY A LAWSUIT OR COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. I UNDERSTAND THAT THE FULL ARBITRATION PROVISION IS CONTAINED IN THE EVIDENCE OF COVERAGE (EOC). I AGREE TO GIVE UP MY RIGHT TO A JURY TRIAL AND ACCEPT THE USE OF BINDING ARBITRATION. Your application will not be accepted without your signature below.

DATE: _____ RETIREE'S SIGNATURE: _____

FUND OFFICE USE ONLY (Please do not write in this space)

NEW RETIREE COBRA
 OPEN ENROLLMENT DATE OF QUALIFYING EVENT: _____
 NEW DEPENDENT
 DELETE DEPENDENT

REMARKS: _____
 DATE: _____ BY: _____

Choice of Dental Plans

Direct Payment and Kaiser Permanente Plan

Optional Benefit for Retired Participants and COBRA Qualified Beneficiaries

When you are eligible for hospital-medical benefits, regardless of which plan you choose, you are also eligible to participate in one of the Fund's three dental plans. Whichever dental plan option you choose as the Participant, your Dependents must be enrolled in the same plan.

Dental plan options are outlined on the Comparison of Dental Plans. The plans are, however, explained in greater detail in each of the plan's official summary of benefits, exclusions and limitations.

If, after reviewing the Comparison of Dental Plans, you would like to see more information about a specific dental plan option before you make a change, call the Trust Fund Office to request a copy of the official summary of benefits, exclusions and limitations.

If You Are an Active Participant

Dental coverage is automatic under the self-funded Delta Dental plan. You can change that plan if you do so **within 60 days** of first becoming eligible as an Active Participant otherwise you can change your dental plan only during Open Enrollment (OE).

If You Are a Retired Participant

Retirees: You may not enroll in a dental plan without a hospital-medical plan.

Dental benefits are optional and are available at an additional cost. If you are a Retired Participant and you enroll for the optional dental coverage, you must keep this coverage for a minimum of 36 months. If you cancel the dental coverage before 36 months, you will also be cancelling your hospital-medical plan (and the vision plan if you have enrolled for that optional benefit). If you are unsure whether you have met the 36-month provision, call the Trust Fund Office for assistance. **NOTE:** If you do not enroll in the dental plan when it is first offered to you or you cancel it after 36 months, you may not be given the opportunity to enroll at a later date. The Open Enrollment (OE) period is only for changing dental plans and not for enrolling if you originally declined the coverage or you cancelled your coverage after 36 months.

If You Are a COBRA Qualified Beneficiary

In order to have dental coverage, you must select the Core Plus Package when you first enroll for COBRA Continuation Coverage. The COBRA Core Plus Package includes the dental **and** vision coverage. You cannot select one without the other and there is an additional cost for these benefits. If you are a COBRA Qualified Beneficiary, you may not have the dental and vision option without a hospital-medical plan.

Dental Benefit Plan Options

1. Delta Dental

1 800 765 6003

www.deltadentalins.com

Delta Dental is the Fund's self-funded dental plan administered by Delta Dental of California.

You should carefully read the Delta Dental plan brochure which contains the "Table of Allowances" (the list of covered dental services and how much the Plan will pay for each covered dental service—after your annual Deductible, where applicable) and explains the benefits, exclusions and limitations of the self-funded dental plan. **Important:** Only the dental services listed in the "Table of Allowances" are covered by the Plan. Charges that exceed the amounts listed in the Table of Allowances are your responsibility to pay in addition to any applicable Plan Year Deductible as are all charges that exceed the annual Plan Year Maximum.

If you choose to remain with Delta Dental, you have the freedom to select your own dentist. However, you may wish to consider using dentists who contract with Delta Dental under either the Delta Premier or Delta PPO networks. Dentists who participate under either of these networks have had their fees pre-approved by Delta Dental and are not permitted to charge you more than the pre-approved fees.

The difference between the "Premier" network and the "PPO" network is that the dentists in the Delta "PPO" network have agreed to accept lower fees for their services. This will save you money based on the cost of the covered dental services listed in the "Table of Allowances".

You may change this plan during the first 60 days of becoming an Active Participant. Once the 60 day period has elapsed, you can change this plan only during Open Enrollment (OE).

Orthodontic services are not covered under the Delta Dental plan.

2. DeltaCare USA

1 800 422 4234

www.deltadentalins.com

DeltaCare USA is a fully insured pre-paid Dental Health Maintenance Organization (DHMO). Under this type of plan, you must pre-select your dental office or dentist from a list of participating dental providers.

Before you decide upon this type of plan, you should very carefully read the DeltaCare USA plan brochure which contains the schedule of covered dental services and explains the benefits, exclusions and limitations of the plan. Dental services not listed in the schedule of covered dental services are not covered by the plan. Ask questions before you make a change because you cannot change to another plan until the next Open Enrollment (OE).

Under the DeltaCare USA plan, there is no annual Deductible nor is there a Plan Year maximum. Most covered dental services have set Copayments and some covered dental services have no Copayment.

Orthodontics are covered under the DeltaCare USA plan with a referral by your DeltaCare USA dentist and approved by DeltaCare USA. You must only use a DeltaCare USA contracting orthodontist.

3. UnitedHealthcare Dental
1 800 999 3367
www.myuhc.com.

UnitedHealthcare Dental is a fully insured pre-paid DHMO. Under this type of plan, you can use only **“in-network”** dentists. To locate an **“in-network”** dentist, visit the UnitedHealthcare Dental website and click **“Find a Dentist”**. An **“in-network”** dentist is one that participates in the UnitedHealthcare Dental **“CA Select Managed Care Direct Compensation”** plan. You do not need to **“pre-select”** a dentist, but you must always use an **“in-network”** dentist. Dentists are available only in California.

Before you decide to enroll in the UnitedHealthcare Dental plan, you should carefully read the official plan materials which contains the schedule of covered dental services and explains the benefits, exclusions and limitations of the plan. Dental services not listed in the schedule of covered services are not covered by the plan. Ask questions before you make a change because you cannot change to another plan until the next **Open Enrollment (OE)**

Under this plan, there is no Plan Year Deductible or Plan Year maximum. Most covered dental services have set Copayments and some covered dental services have no Copayment.

Orthodontics are covered under the UnitedHealthcare Dental plan with a referral by your United Healthcare dentist. You must always use an **“in-network”** orthodontist contracting under the **“CA Select Managed Care Direct Compensation”** plan.

Open Enrollment for the Dental Plans

Open Enrollment (OE) for the dental plans begins October 1st and ends on December 15th for a January 1st effective date. The purpose of OE is to enable you to change your dental plan option.

Retired Participants

If you are a Retired Participant who declined enrollment in the optional dental plan when you were first eligible or if you are a Retired Participant who cancelled the optional dental coverage after 36 months, you will not be able to enroll for dental benefits during OE.

COBRA Qualified Beneficiaries

If you are a COBRA Qualified Beneficiary who declined enrollment in a dental plan when you were first eligible for COBRA or who enrolled for the Core Plus Coverage and later cancelled the dental coverage, you will not be able to enroll for dental benefits during OE.

The Dental Plan Enrollment Form

If you decide to change dental plans, either during OE or within 60 days of first becoming eligible as an Active Participant, you must complete an Active and Retired Plans Dental Enrollment Form, see sample form to the right (current to the date of the printing of this SPD). Be sure to complete the form by answering all of the questions, sign, and date then mail the completed form to the Trust Fund Office so that it is received no later than 60 days after your initial eligibility date if you are an Active Participant. If you are submitting it during OE, it must be received before December 15th. For Active Participants, once 60 days from the date you first became eligible as an Active Participant has passed, you can only change your dental plan during OE.

		CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA 220 Campus Lane, Fairfield, CA 94534-1499 Telephone: (707) 864-3300 or Toll-Free at 1-888-245-6005 E-Mail Address: customerservice@norcalcementmasons.org Website: http://www.norcalcementmasons.org		FUND OFFICE USE ONLY (42) EFF. DATE: HOID: CM ELIGIBILITY CODE/GROUP NO.:	
ACTIVE & RETIRED PLANS DENTAL ENROLLMENT FORM PARTICIPANT INFORMATION (Please print or type in black ink only)					
SOCIAL SECURITY NUMBER		NAME: FIRST		MIDDLE LAST	
RESIDENCE ADDRESS (not Post Office Box)			CITY		STATE ZIP CODE
TELEPHONE NO. ()	LOCAL UNION	DATE OF BIRTH MONTH DAY YEAR		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
DENTAL PLAN OPTIONS IMPORTANT: You and your Dependents must be enrolled in the same Dental Plan. Check only one box.					
<input type="checkbox"/> Delta Dental. You may seek dental care from any dentist but, your out-of-pocket expense is lower if you use a participating Delta Dental dentist.					
<input type="checkbox"/> DeltaCare USA. You must select a Dental Office from Delta Care Participating Dental Offices Directory: Name of Dental Office: _____ Facility No.: _____					
<input type="checkbox"/> UnitedHealthcare Dental. You must select a dentist or dental group from UnitedHealthcare Dental Provider Directory: Name of Dentist: _____ Dentist No.: _____					
DEPENDENT INFORMATION (List all eligible dependents to be enrolled. Use back page if more space needed.)					
FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM EMPLOYEE)		DATE OF BIRTH MO / DY / YR	DEPENDENT RELATIONSHIP	FUND OFFICE USE ONLY <input type="checkbox"/> STUDENT <input type="checkbox"/> STUDENT <input type="checkbox"/> STUDENT <input type="checkbox"/> STUDENT	
1.			SPOUSE		
2.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
3.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
4.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
5.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
<i>I understand that once I have selected a Plan, I cannot change to another Plan until the next Open Enrollment. I agree to be bound by the benefits, deductions, co-payments, exclusions and other terms of the Plan group agreement. Your application will not be accepted without your signature below. Please return this Enrollment Form to the Fund Office.</i> Important: If you enroll in DeltaCare USA or UnitedHealthcare Dental, any dispute that may arise between you and the Dental Plan will be subject to binding arbitration.					
Date:		Participant's Signature: _____			
FUND OFFICE USE ONLY (Please do not write in this space)					
<input type="checkbox"/> NEW EMPLOYEE <input type="checkbox"/> OPEN ENROLLMENT		REMARKS:			
<input type="checkbox"/> COBRA - DATE OF QUALIFYING EVENT _____		DATE:	BY: _____		
Revised 10/3/2014					

Always check the Trust Funds' website for the most recent form.

If you have decided to change from the Delta Dental Plan to one of the optional dental plans or vice versa, once the Active and Retired Plans Dental Enrollment Form is processed by the Trust Fund Office, you will be notified **in writing**, confirming the plan and the effective date of the change.

Do not assume your dental plan has changed until you receive a confirmation letter from the Trust Fund Office.

The Vision Plan

Direct Payment and Kaiser Permanente Plan

Optional Benefit for Retired Participants and COBRA Qualified Beneficiaries

Vision Service Plan (VSP)

1 800 877 7195

www.vsp.com

The Vision Service Plan (VSP) Copayments are shown on the Comparison of Benefits Plans.

You should carefully read the VSP summary of benefits, exclusions and limitations before you obtain vision services. Some vision services and optical supplies may not be covered by the plan. If you choose to have vision or optical services that are not covered by the plan, you will be fully responsible for payment of any charges for those services.

If You Are an Active Participant

You are automatically enrolled in the VSP regardless of hospital-medical plan in which you are enrolled.

If You Are a Retired Participant

The VSP is an optional benefit choice available to you and your eligible Dependents at an additional cost. If you choose to enroll in the optional VSP, you must keep it for a minimum of 36 months. If you cancel the VSP **before** 36 months, you will also be cancelling your hospital-medical plan (and optional dental plan if you have enrolled for that coverage). If you are unsure whether you have met the 36-month provision, call the Trust Fund Office for assistance. **NOTE:** If you do not elect the optional VSP coverage when it is first offered to you or you cancel it after 36 months, you will not be given an opportunity to enroll at a later date.

If You Are a COBRA Qualified Beneficiary

In order to have VSP benefits, you will be required to select the Core Plus Package when you first enroll for COBRA Continuation Coverage. The COBRA Core Plus Package includes a dental plan and VSP for an additional cost. If you are a COBRA Qualified Beneficiary, you cannot have the dental and vision option without a hospital-medical plan.

If You Are a Kaiser Permanente Plan Member

You have a vision **examination** benefit as part of the hospital-medical plan. You can choose to use the vision examination benefit through Kaiser Permanente or through VSP.

If you or your Dependents choose to use a Kaiser Permanente Plan provider for the eye examination and you need glasses or contact lenses, while they can be purchased through Kaiser Permanente, you would be required to pay the full cost for the glasses or contact lenses and then file a Claim with VSP for reimbursement in accordance with Plan benefits. You can request a Claim form from VSP (you may also print one online from the VSP website) or the Trust Fund Office.

If you or your Dependent chooses to use a VSP contracting provider for glasses or contact lenses, you should secure a prescription order from your Kaiser Permanente doctor then use a VSP contracting provider for the glasses or contact lenses.

Grievance Procedures for Dental and Vision Plans

Delta Dental, DeltaCare USA, UnitedHealthcare Dental and VSP have grievance procedures for handling complaints. If you or your Dependent have a complaint with one of these companies, you should first seek resolution using the company's complaint procedure before appealing to the Board of Trustees of the Cement Masons Health and Welfare Trust Fund for Northern California. If, however, the complaint is pertaining to your eligibility under the Plan, contact the Trust Fund Office.

Death and Accidental Death and Dismemberment Benefits

Active Participants

Direct Payment and Kaiser Permanente Plan

Regardless of which hospital-medical plan you have chosen as an Active Participant, you will also be entitled to Death and Accidental Death and Dismemberment Benefits. Eligible Dependents also have a Death Benefit.

Death Benefits for Active Participants

If you die while eligible as an Active Participant or within 31 days from the loss of your eligibility as an Active Participant, your designated beneficiary will receive a Death Benefit in the amount of **\$10,000**. Your beneficiary or authorized representative must notify the Trust Fund Office of your death and the beneficiary must provide a copy of the death certificate and complete an Employee Proof of Death form.

Extended Death Benefits for Former Active Participants

If you are a former Active Participant who was **1)** under the age of 60 **and 2)** totally disabled on the date your eligibility as an Active Participant terminated, you may be entitled to extend the Death Benefit until the earlier of age 65 or the date you are no longer totally disabled. If you think you may be qualified for this benefit, contact the Trust Fund Office for the necessary form. You must submit proof of total disability within one year from the loss of your eligibility as an Active Participant and then annually until your 65th birthday, at which time the Death Benefit ends.

Accidental Death Benefits for Active Participants

If while eligible as an Active Participant, you sustain bodily injuries solely through external, violent and accidental means and your death occurs within one year from the date of the accident **as a result of those injuries**, your designated beneficiary will receive an Accidental Death Benefit in the amount of **\$10,000** in addition to the regular Death Benefit.

Dismemberment Benefits for Active Participants

If, while eligible as an Active Participant, you sustain injuries through external, violent and accidental means and **as a result of those injuries** and within one year following the accident in which you were injured you suffer the loss of a hand by severance at or above the wrist, loss of a foot by severance at or above the ankle or irrecoverable loss of sight of an eye, a Dismemberment benefit of \$5,000 will be payable.

Limitations for the Accidental Death and Dismemberment Benefits

- No more than \$10,000 is payable for any one accident that results in accidental death and/or dismemberment.

Exclusions for the Accidental Death and Dismemberment Benefits

No Accidental Death or Dismemberment Benefit will be payable if the loss is from:

- Disease, bodily or mental infirmity, medical or surgical treatment, ptomaine or bacterial infection;
- Suicide, attempted suicide or any self-inflicted injury or condition;
- War, acts of war or service of any kind in any armed force of any country;
- Participation in or engagement in any felonious acts;
- Intake of any drug, medication or sedative;
- Intake of alcohol in combination with any drug, medication or sedative; **or**
- Use of alcohol, non-prescription drugs or controlled substances, such as PCP, LSD or any hallucinogens, cocaine, heroin or any other type of narcotic, amphetamines or other stimulant, barbiturates or other sedative or tranquilizer or any combination of any of these substances.

Naming Your Beneficiary

You are free to name any person(s) as your beneficiary on a form approved by the Board. Generally, you will designate your beneficiary in the Enrollment Form. If you would like to designate more than one beneficiary, there is a box on the Enrollment Form for that purpose. Simply check that box and the applicable form will be mailed to you by the Trust Fund Office.

You are free to change your beneficiary at any time. If you do not designate a beneficiary or your designated beneficiary is no longer living at the time of your death, any death benefits due, including, when applicable, the Accidental Death benefit, will be paid to your spouse. If you have no spouse, benefits will be paid to your surviving relatives in the following order: your child(ren), if none, your mother and father, if none, your brothers and sisters. If none of these family members survive you, the benefit will be paid to your estate.

The Trust Fund will only pay benefits to the beneficiary listed on the Board approved form and on file with the Fund prior to the date of death.

It is important that you keep your beneficiary designation up-to-date, especially if you have named a spouse and you later divorce.

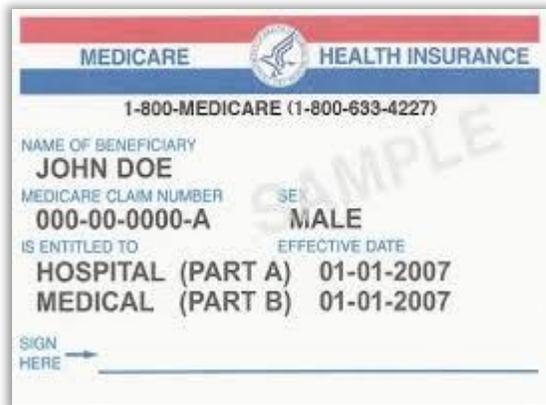
Death Benefits for Dependents of Active Participants

Eligible Spouse	\$5,000
Dependent Children	
6 months to 26 years	\$ 500
24 hours to 6 months:	\$ 100

The Direct Payment Plan For Retired Participants and Dependents Eligible for Medicare

Enroll for Medicare

On the first day of the month in which you or your Dependent spouse turn age 65, you are Eligible for Medicare.



Generally, Hospital (Part A) is automatic, premium free and requires no enrollment (for most workers).

Medical (Part B) requires enrollment 3 months before your 65th birth date. ¹

You or your Dependent spouse may also be Eligible for Medicare prior to age 65 if you have qualified for a Social Security Disability. In this case, you must notify the Trust Fund Office immediately upon receipt of your Medicare ID Card.

If you or a Dependent fails to enroll for Medical (Part B) when you are first eligible, a late enrollment penalty may be added by the Social Security Administration to your monthly premiums when you later enroll ¹. You should always consult with the Social Security Administration about their rules.

If you or your Dependent are eligible for Medical (Part B) but do not **enroll**, the Plan will limit reimbursement on your Claims to what it would have paid had you been enrolled in Medical (Part B). This means you will have considerably more out-of-pocket expense to pay on your health care expenses if you do not enroll for Medical (Part "B"). ¹

Footnote 1. If you or your Dependent spouse continue to work on or beyond the date you reach age 65 and have Group Plan coverage as an employee or as a dependent, Medicare allows you to defer enrollment in Medical (Part B) while you have Group Plan coverage. If this applies to you, you should be aware that when your coverage as an employee or dependent under the Group Plan ends, you have a certain period of time to apply for Medical (Part B) **without a late enrollment penalty**. You should discuss the time frame with the Social Security Administration and advise the Trust Fund Office, in writing, of your intention to defer enrollment in Medical (Part B).

Covered Expenses

The term "Covered Expenses" refers to hospital and medical services and supplies that are covered under the Plan, subject to all other Plan provisions.

Supplemental Hospital Benefits

If you are confined in a Hospital or Skilled Nursing Facility (SNF), the Plan will, subject to all other Plan provisions, pay the Hospital during the Medicare Benefit Period, the amount of the Hospital (Part A) Deductible plus any copayment or coinsurance for inpatient Hospital expenses.

Medicare Benefit Period

All Hospital or SNF confinements will be considered to have occurred during one Medicare Benefit Period, unless you have not been confined in a Hospital or SNF for 60 consecutive days.

Supplemental Medical Benefits

If you receive medical treatment, medical services, supplies or home health care services of the type that are covered by Medical (Part B), the Plan will, subject to all other Plan provisions, pay the amount of the Medical (Part B) Deductible plus Plan Benefits for Covered Expenses that exceed the amount payable by Medicare.

No-Cost Preventive Care Services

See www.healthcare.gov/preventive-care-benefits/ for a complete list of no-cost Preventive Care Services when you use a provider that is part of the Fund's Preferred Provider Plan network.

"Private Contracting" and Medicare

Under "private contracting" a Physician can "opt-out" of Medicare reimbursement for Medicare covered services. This means that the Physician may charge you any fee he chooses for his services and you are responsible for payment of those services.

If you (or your Dependent) choose to enter into "private contracting" with a Physician, that Physician must tell you, in advance, that you are agreeing to a "private contract". The "private contract" between you and your Physician must clearly state that:

- You are giving up your right to have Medicare pay for the services;
- You agree that the Physician will not bill Medicare;
- You understand that Medicare will not pay for the services and that it is not likely that other insurance will pay; and
- You have the right to receive services from Physicians and practitioners whose services are covered under Medicare and whose bills Medicare would pay.

Caution: If you enter into "private contract" with a Physician, the Fund will only pay 20% of Allowed Charges for Medicare covered services. Any other expenses or charges will be your responsibility. For example, if your Physician charges \$150 for an office visit and the Allowed Charge is \$80, the Fund would pay \$16 (20% of \$80). You are responsible for the entire balance of \$134. As you can see from this example, you can incur a substantial amount of out-of-pocket expense under a "private contracting" arrangement.

This example assumes that the services are eligible under Medicare. In other words, had the Physician not “opted out” of Medicare, the services would have been covered by Medicare. If you incur expenses that are not covered by Medicare in a “private contracting” arrangement, the Fund will not pay any of the billed charges. You would be responsible for the full payment.

Before entering into a “private contract”, contact the Trust Fund Office.

The Direct Payment Plan For Active and Retired Participants and Dependents Not Eligible for Medicare

Under the Direct Payment Plan for Active and Retired Participants and Dependents who are not Eligible for Medicare, some Covered Expenses require a prior approval before they are obtained and some Covered Expenses require that you use certain health care providers in order to receive full Plan benefits. You will pay more of your Covered Expenses if you do not obtain a prior approval or if you use more costly health care providers.

1. Always review the Comparison of Benefit Plans for an overview on Copayments, Deductible and coinsurance amounts;
2. If you are an Active Participant **enrolled in either** the Direct Payment or Kaiser Permanente Plan, you can lower your annual Deductible when you and your spouse, if any, participate in the Healthy Structures Promise program;
3. Always use Participating Hospitals and Participating Providers from the Fund's Preferred Provider Plan network to lower your share of cost on your covered health care services;
4. Always use only Participating Providers from the Fund's Preferred Provider Plan network for covered **no-cost** Preventive Care Services that are medical related;
5. Always use a Contracting Pharmacy from the OptumRx network for covered **no-cost** Preventive Care Services that are "Drug" related;
6. If you live in California, always use a Value-Based Site from the Fund's Preferred Provider Plan network for routine total hip or knee replacement surgery, non-emergency outpatient arthroscopy, cataract or colonoscopy procedures to lower your share of the cost for these procedures;
7. Always have a Utilization Review (UR) through the Fund's Professional Review Organization (PRO) before an elective admission to the Hospital (where you will stay overnight) so you do not pay extra coinsurance;
8. Always obtain a Pre-Authorization Review through the Fund's Professional Review Organization (PRO) when one is required so you do not pay extra coinsurance;
9. If you are a female Active Participant or the spouse of an Active Participant and you are pregnant, enroll and participate throughout your pregnancy in the Future Moms' program in order to have useful tools to use throughout your pregnancy and to eliminate the Labor and Delivery Copayment (see page 64).

Professional Review Organizations (PRO)

Professional Review Organizations are companies under contract with the Fund that determine whether an inpatient Hospital confinement is Medically Necessary, including the number of authorized days and/or whether a proposed non-emergency outpatient service is Medically Necessary.

- Anthem Blue Cross (ABC) is the Fund's PRO for Utilization Review (UR) for inpatient hospitalizations (see pages 61-62) and for Pre-Authorization Review in connection with bariatric surgery procedures; **and**
- Pacific Health Alliance (PHA) is the Fund's PRO for Pre-Authorization Review of certain non-emergency outpatient services (see list on page 58) with the exception of bariatric surgery procedures.

Covered Expenses

The term "Covered Expenses" refers to hospital and medical services that are covered by the Direct Payment Plan, subject to all other Plan provisions, including the Maximum Plan Allowance (MPA) which is discussed on page 52.

Included in Covered Expenses are charges for:

1. Medical or surgical services provided by a Physician. Some procedures require a Pre-Authorization Review.
2. Charges in connection with the treatment of substance abuse, mental health or psychiatric disorders
3. Preventive Care Services mandated by the health care law:
 - No cost to you when you use Participating Providers;
4. Chiropractic services.
5. Nursing services by a licensed registered graduate nurse (RN) or licensed vocational nurse (LVN).
6. Hospital inpatient or outpatient services.
7. Skilled Nursing Facility (SNF) services.
8. Occupational, physical or speech therapy services by a licensed health care provider not related to you. Services require Pre-Authorization Review. Habilitative/Habilitation services in connection with developmental delays for an Eligible Individual who has never acquired normal functional abilities is not covered.
9. Ambulatory Surgical Center (ASC) services.

10. Hospice services upon a referral by the Plan's case management program (see page 51).
11. Home Health Care services upon a referral by the Plan's case management program (see page 51).
12. Mastectomy services, including reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance and prosthesis and treatment of physical complications of all states of mastectomy, including lymphedemas (see page 79 "Benefits Required by Law" "Women's Health and Cancer Rights Act").
13. Weight-loss surgery (i.e. bariatric surgery) in connection with the treatment of morbid obesity if your **B**ody **M**ass **I**ndex (BMI) is greater than 35 **and** complicated by any of the following:
 - Life-threatening cardiopulmonary conditions;
 - Difficulty controlling diabetes mellitus or hypertension;
 - End stage renal disease;
 - Severe sleep apnea (documented by a sleep study);
 - Severe lower extremity edema with ulceration;
 - Symptomatic degenerative joint disease, resulting in ambulatory difficulties (cane, walker, wheelchair); **or**
 - Stress incontinence with gynecologic abnormalities.

Weight loss surgical procedures (i.e. bariatric surgical procedures) must be Pre-Authorized by Anthem Blue Cross. If the surgery is approved, you must use a Blue Distinction® Center for Bariatric Surgery that is part of the Fund's Preferred Provider Plan network. Call 1 800 274 7767.

Only one of the following weight loss surgical procedures will be covered in a lifetime:

- Roux-en Y gastric bypass
 - Gastric stapling or banding
 - Biliopancreatic bypass
14. Hearing aid devices.
 15. Dental services for the following:
 - Treatment to alleviate the damage to broken or injured teeth as a result of an accidental bodily injury (no payment will be made for the replacement of teeth, in whole or in part); and
 - Medically Necessary surgery not covered under the Fund's dental benefits.
 16. Routine Physical Examinations.
 17. The following medical services and supplies:
 - Anesthesia and its administration;

- Blood and blood products;
- Surgical dressings, splints, casts and other devices for the treatment of burns or the reduction of fractures and dislocations;
- Diagnostic tests, x-rays and laboratory services for treatment or diagnostic purposes. High-tech imaging services such as MRIs, CT and PET scans require Pre-Authorization Review;
- Radiation therapy. Requires Pre-Authorization Review;
- **Durable Medical Equipment (DME)** including, but not limited to hospital beds, wheelchairs, oxygen and prosthetic devices or corrective lenses required after cataract surgery. Charges of \$500 or more require a Pre-Authorization Review;
- Professional ambulance services if you or your eligible Dependent requires paramedic support from the place where you are injured or stricken by illness to or from a Hospital or Physician's office. Air ambulance transportation is covered only if based upon the location and nature of the illness or injury, air transportation is cost-effective and Medically Necessary to avoid the possibility of serious complications or loss of life;
- Immunizations and inoculations (these may also be covered under Preventive Care Services with no cost sharing when you use a Participating Provider);
- Outpatient intravenous therapy when authorized by and under the direct supervision of a Physician for the treatment of an illness that would otherwise require hospitalization; **and**
- Newborn and well-child visits, including routine immunizations from birth through 24 months of age, according to the schedule of the American Academy of Pediatrics. This benefit is only for the Dependent children of an **Active Participant. However, these expenses may be a Covered Expense under ACA Preventive Care Services. In that case, they are covered for the Dependent children of all Plan Participants when a Participating Provider is used.**

Case Management Program

Case management is a program designed to assist you or an eligible Dependent in making important decisions concerning your health care and in dealing with the health care system. Anthem Blue Cross, the organization currently performing **Utilization Review (UR)**, also provides case management for the Fund.

Case management can involve you, your family, health care providers, and the Fund in assessing and coordinating the best possible care in each situation and can help move you or your eligible Dependent from an acute care Hospital setting to an alternative, more comfortable and efficient setting as soon as it is medically safe to do so. Case management professionals can arrange for your care, nursing and equipment needs at the time of discharge from an acute care Hospital because Anthem Blue Cross has the ability to select cases that may benefit from case management since its staff reviews and monitors Hospital admissions through the **Utilization Review (UR)** program.

Maximum Plan Allowance (MPA)

The Plan limits the dollar amount allowed for certain Covered Expenses. The term used for Covered Expenses for which there is a maximum dollar amount allowed is “Maximum Plan Allowance (MPA)”. For a list of Covered Expenses that are subject to a MPA, refer to the MPA table below.

Where Covered Expenses on “**Hospital charges**” are limited to an MPA, and you live within California, you and your eligible Dependents are provided with alternative provider choices referred to as **Value- Based Sites**. Using these providers will save you money on your share of the cost for covered health care services.

Maximum Plan Allowance (MPA) Table

		MPA	Your Share
Inpatient Hospital Charges	Routine hip or knee replacement surgery ¹ (Utilization Review is required by Anthem Blue Cross).	\$30,000	You pay all Hospital charges that exceed \$30,000 in addition to your Deductible and coinsurance.
Outpatient Hospital Charges	Outpatient arthroscopy procedures ¹ (Pre-Authorization Review is required by the Care Counselor).	\$ 6,000	You pay all Hospital charges that exceed \$6,000 in addition to your Deductible and coinsurance.
	Outpatient cataract procedures ¹ (Pre-Authorization Review is required by the Care Counselor).	\$ 2,000	You pay all Hospital charges that exceed \$2,000 in addition to your Deductible and coinsurance.
	For outpatient colonoscopy procedures (Pre-Authorization Review is required by the Care Counselor). ^{1,2}	\$ 1,500	You pay all Hospital charges that exceed \$1,500 in addition to your Deductible and coinsurance.
Routine Physical Examination	Active Participant and Spouse ³ .	\$300	You pay all charges that exceed \$300.
	Active Dependent Children ³ .	\$200	You pay all charges that exceed \$200.
	Retired Participant and Spouse ³ .	\$300	You pay all charges that exceed \$300.
Chiropractic Care	Visits	\$40 per visit 40 visits per Plan Year	You pay all charges that exceed \$40 and 40 visits in addition to your Deductible.
	X-Rays	\$300 per Plan year	You pay all charges that exceed \$300 in addition to your Deductible.
Hearing Aids	Allowed every 36 months	\$1,000 per ear/device	You pay all charges that exceed \$1,000 in addition to your Deductible.
Ambulatory Surgical Centers	All Covered Expenses at a <u>Non-Participating Ambulatory Surgical Center</u>	\$500 per day	You pay all charges that exceed \$500 per day in addition to your Deductible

See footnotes on the next page.

Footnote 1. The Maximum Plan Allowance (MPA) for **Hospital charges** in connection with routine total hip or knee replacement surgery; arthroscopy; cataract or colonoscopy procedures does not apply if you reside outside of California.

Footnote 2. Colonoscopy procedures billed as an ACA Preventive Care Service by a Participating Hospital or Participating Provider that is part of the Fund's Preferred Provider Plan network are payable by the Plan at 100%. You pay zero.

Footnote 3. Routine physical examinations billed as an ACA Preventive Care Service by a Participating Provider that is part of the Fund's Preferred Provider Plan network are payable by the Plan at 100%. You pay zero.

Comparison of Benefits

Always refer to the Comparison of Benefit Plans which is a companion document to this SPD. Any changes in Copayments, Deductible or coinsurance will always be on the most current Comparison of Benefit Plans located on the Trust Funds' website.

Freedom to Choose Your Own Health Care Providers

Under the Direct Payment Plan, you and your eligible Dependents have the freedom to choose your own health care providers, such as Hospitals, Physicians, laboratories, radiologist, and others various types of providers who are qualified by their license to provide services covered by the Plan.

When you and your Dependents choose to use Participating Hospitals and Participating Providers from the Fund's Preferred Provider Plan network, a Value-Based Site that is part of the Fund's Preferred Provider Plan network or you use a Contracting Pharmacy that is part of the Fund's Pharmacy Benefit Manager's (PBM) network, your share of the cost for covered health care services is lower.

The Preferred Provider Organization (PPO)



A Preferred Provider Organization (PPO) is a managed care organization of Hospitals and other licensed health care providers who have an agreement to accept lower fees for their services. The lower fees are referred to as "negotiated rates". The agreements are between Anthem Blue Cross (ABC) and the Participating Hospitals and Participating Providers.

Among the services for which the Fund contracts with ABC is access to Preferred Provider Plan networks. This allows you and your Dependents to receive lower negotiated rates on Covered Expenses as well as a lower coinsurance amount—both of which reduce your share of the cost for Covered Expenses.

The Preferred Provider Plan (PPO Plan)

ABC has several Preferred Provider Plan networks. The Preferred Provider Plans used by the Fund are **1) the Advantage PPO** network if you live in California; **and 2) the BlueCard PPO** national network if you live or are traveling elsewhere in the United States.



The BlueCard PPO

This is the national PPO network to be used outside of California but still within the United States. Using **BlueCard PPO** Participating Hospitals and Providers assures you of receiving lower negotiated rates for Covered Expenses as well as lowering your coinsurance amount—both reduce your share of the cost for Covered Expenses.

No coverage is provided under the Direct Payment Plan for services received outside of the United States, its Territories or Possessions with the exception of Emergency Services as defined by the Plan.

Before you receive medical services, you should confirm whether you are using a Participating Hospital and/or Participating Provider from the Fund's Preferred Provider Plan network, the Advantage PPO or BlueCard PPO national network.

How to Locate a Participating Hospital or Provider that is Part of the Fund's Preferred Provider Plan Network

The easiest way to find Participating Hospitals and/or Providers is to call the PHA Care Counselor. You can also use the ABC website (www.anthem.com.ca). If you choose to use the ABC website, you will choose the "USEFUL TOOLS" section and then "FIND A DOCTOR".

CAUTION: If you use the ABC website, you should do so only for limited services because not all features on the website apply to you. For instance, the Drug, Dental and Vision Benefits are not through ABC so you will not use those features on the ABC website. When using the ABC website, do so with caution because some of the information you may require will come from companies other than ABC.

When you or your Dependents register with the ABC website, you will need a user name and password. This will give you access to the names and locations of Participating Hospitals and Providers that are part of the Preferred Provider Plan network that applies if you live within California. However, if you are living or traveling outside of California (within the United States) you will need to enter the state in which you are located in order to find names and locations of **BlueCard PPO** Participating Hospitals and Participating Providers.

You can also use the website as a guest but you must enter the correct Preferred Provider Plan network in order to find the correct Participating Hospitals and Participating Providers that are part of the Fund's Preferred Provider Plan network.

Non-Participating Hospitals and Non-Participating Providers

When you use a **Non-Participating Hospital** or a **Non-Participating Provider**, you will generally experience a higher share of costs for Covered Expenses:

1. You will not receive lower negotiated rates for Covered Expenses;
2. You will, generally, pay a higher coinsurance for Covered Expenses;

3. You will be responsible for paying all charges that exceed the Plan's "Allowed Charge"; **and**
4. Any Copayments, Deductible and/or coinsurance you pay for Covered Expenses (with the exception of Emergency Services at a Hospital) will not count toward your Plan Year Out-of-Pocket Maximum.

The Healthy Structures Programs

Understanding the Healthy Structures programs before you receive covered services will help you and your enrolled Dependents use your Plan benefits to the fullest and experience the greatest cost savings. The following Programs are available to help get the maximum benefits at the lowest cost.

1. The Promise program (**this program applies to both the Direct Payment and Kaiser Permanente Plan for Active Participants and their spouse**);
2. The Care Counseling and Pre-Authorization Review programs for non-emergency outpatient services other than visits to your primary care Physician;
3. The Value-Based Site program if you live within California; **and**
4. The Future Moms' program (Active Benefits only).

The "Promise" Program for Active Participants and Eligible Spouses

Direct Payment and Kaiser Permanente Plan

Regardless of which hospital-medical plan you have chosen, as an Active Participant, you and your spouse, if any, are eligible to participate in the Healthy Structures Promise program. The Promise program involves all of the following steps below if you are enrolled in the Direct Payment Plan and steps 1 and 2 only if you are enrolled in the Kaiser Permanente Plan.

- Step 1** Under the Promise program, you and your spouse are entitled to receive a free annual biometric health screening. The screening includes a simple blood test, blood pressure check as well as recording your height, weight and body mass index. This information is to help identify any potential health-risk factors that can lead to chronic illness if not detected early. Knowing this information and then working with your doctor to improve your health can help you live a healthier and more productive life;

The results of the biometric health screening are absolutely confidential – The Trust Fund Office knows only that you and your spouse, if any, have completed the screening; nothing more. It is your decision and that of your spouse as to whether you wish to share the results of the screening with your Physician.

- Step 2** Along with completing the free biometric health screening, you must agree to keep the Trust Fund Office informed of your current contact information, including your mailing address, the mailing addresses of your Dependents if they live at a different location, your telephone number and your email address, if you have one. Having current contact information is very important so that the Trust Fund Office can communicate with you and your eligible Dependents about important benefit-related information; **and**
- Step 3** If you are a Direct Payment Plan Participant, you and your spouse, if any, agree to secure a Pre-Authorization Review from the Care Counselor prior to any of the non-emergency outpatient procedures listed on page 58.

By taking the steps described above, you will lower the annual Plan Year Deductible for you and your eligible Dependents.

More information about the Healthy Structures Promise is in the New Eligible Packet along with the necessary forms if you wish to participate in the Promise program when you first become eligible.

If you and your spouse decide not to participate in this program when you first become eligible for benefits, you will remain in the higher Deductible Basic Plan. If you and your spouse change your mind about participating in the Promise program, you will be given another opportunity during the annual Open Enrollment (OE). The Promise program Open Enrollment starts on October 1st and ends on December 31st. When you complete all aspects of the program by the end of the OE, you will have the lower annual Deductible beginning on January 1st.

If you and your spouse, if any, fail to carry out the commitments of the Promise program, your Plan Year Deductible will go back to the higher Basic Plan Deductible.

The Care Counseling and Pre-Authorization Review Programs

Call 1 855 754 7271

The Care Counseling Program

The Fund's Care Counseling program is administered by Pacific Health Alliance (PHA) and is your "go-to health care resource" when you need:

- Non-emergency outpatient services;
- To obtain a Pre-Authorization Review, when one is required, on non-emergency outpatient services (see the list below);
- To locate Participating Hospitals and Participating Providers that are part of the Fund's Preferred Provider Plan network;
- To locate Value-Based Sites within California for any non-emergency surgical procedure where **Hospital charges** have been limited to a Maximum Plan Allowance (MPA); **and**
- 24/7 nurse advice

Pre-Authorization Review Program for Non-Emergency Outpatient Services

Covered Expenses include non-emergency outpatient services listed below that **require** a Pre-Authorization Review by the Care Counselor **before** you obtain them.

In addition to a Pre-Authorization Review, the surgical procedures listed require that you use a Value-Based Site if you live within California in order to limit your share of costs on your health care services.

Bariatric Surgery

IMPORTANT NOTE: Bariatric surgical procedures are not included in the following list of procedures but do require a Pre-Authorization Review. The Pre-Authorization Review for bariatric surgical procedures is conducted by Anthem Blue Cross (ABC) rather than the PHA Care Counselor. Call ABC at 1 800 274 7767.

Call the PHA Care Counselor before you have any of the non-emergency outpatient services listed below:

1. Arthroscopy surgery;
2. Cataract surgery;
3. Colonoscopy surgery;
4. Diagnostic Imaging, MRI, CT, PET scans;
5. Physical therapy visits;
6. Chemotherapy;
7. Radiation therapy;
8. Genetic testing;
9. Sleep studies;
10. Durable Medical Equipment (DME) of \$500 or more; **and**
11. Routine costs associated with an approved clinical trial.

IMPORTANT: If you do not obtain a Pre-Authorization Review from the Care Counselor when one is required, you will be responsible for paying an additional 20% coinsurance for the cost of the Covered Expenses. This additional coinsurance is over-and-above the usual coinsurance and will not count toward your Plan Year Out-of-Pocket Maximum (i.e., your annual cost sharing limit). If the procedure is an arthroscopy, cataract or colonoscopy, the additional 20% coinsurance will apply to all Covered Expenses in connection with the procedure, including, but not limited to, Hospital or Ambulatory Surgical Center (ASC) charges, and anesthesia charges.

The Care Counselor through Pacific Health Alliance

Active and Retired Direct Payment Plan Participants and Dependents Not Eligible for Medicare

Available 5 days a week. Monday through Thursday from 7:00 AM to 7:00 PM and on Friday from 7:00 AM to 5:00 PM

1 855 754 7271

**Call this same telephone number if you need
to contact the 24/7 Nurse Advice Line**

The Value-Based Site Program

Call the Care Counselor—1 855 754 7271

On page 52 of this SPD, we explained that the Plan limits the dollar amount that it “allows” on Covered Expenses for **Hospital charges** in connection with 4 non-emergency surgical procedures. The term used for this limit is Maximum Plan Allowance (MPA). If you do not live within California, the MPA does not apply.

Value-Based Sites

The Value-Based Site program provides you with Hospital alternatives for obtaining covered services in connection with any of the surgical procedures where **Covered Expenses** for **Hospital charges** have been limited to a **Maximum Plan Allowance (MPA)** (see the table on page 52).

If you live within California, and if you or your eligible Dependents decide not to use a Value-Based Site for any surgical procedure where **Hospital charges** have been limited to a **Maximum Plan Allowance (MPA)**, all **Hospital charges** over the MPA will be your responsibility in addition to the Deductible and the Plan’s usual coinsurance and will not count toward the annual Plan Year Out-of-Pocket Maximum.

Exceptions to Value-Based Sites

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)** for **Hospital charges** in connection with total routine hip or knee replacement, arthroscopy, cataract or colonoscopy procedures **may not apply**.

For Arthroscopy, Cataract or Colonoscopy Procedures

Value-Based Sites are **Ambulatory Surgical Centers (ASC)** that are part of the Fund’s Preferred Provider Plan network.

The illustration below for an arthroscopy procedure demonstrates the difference in costs between what you can expect, **generally**, when using an **Ambulatory Surgical Center (ASC)** instead of the outpatient surgical department of a Hospital—**because actual billed charges and negotiated rates vary between providers for the same services, this illustration is not based on the actual charges or negotiated rate for any one provider**.

A Value-Based Site— Ambulatory Surgical Center (ASC) that is part of the Fund’s Preferred Provider Plan Network		An Outpatient Surgical Department of a Hospital that is participating under the Fund’s Preferred Provider Plan Network	
Billed Charge	\$8,500	Billed Charge	\$11,500
Negotiated rate	\$6,000	Negotiated rate	\$9,500
Maximum Plan Allowance (MPA)	\$6,000	Maximum Plan Allowance (MPA)	\$6,000
Amount over MPA	\$0	Amount over MPA	\$3,500
You owe 20% of MPA	\$1,200	You owe 20% of MPA	\$1,200
You owe the amount over MPA	\$0	You owe the amount over MPA	\$3,500
Total you owe	\$1,200	Total you owe	\$4,700

For Routine Total Hip or Knee Replacement Surgery

Value-Based Sites are **“Designated”** Hospitals throughout California that are part of the Fund’s Preferred Provider Plan network. The PHA Care Counselor can assist you in locating a Value-Based Site and surgeon associated with one of the Value-Based Sites. You may also see a list of Value-Based Sites on the Funds’ website but you are cautioned to always verify that the location is still a Value-

Based Site before you select that Hospital. Your surgeon must also be able to perform surgery at that Hospital.

The illustration below for a routine total hip or knee replacement indicates the difference in cost between what you can expect, **generally**, for various Hospitals in the Preferred Provider network instead of a Value-Based Site “Designated Hospital” in the Preferred Provider Plan network—**because actual billed charges and negotiated rates vary between different providers for the same services, this illustration is not based upon the actual billed charge or negotiated rate for any one provider.**

A Participating Hospital that is Part of the Fund’s Preferred Provider Plan Network THAT IS a Value-Based Site <i>Designated</i> Hospital		A Participating Hospital that is part of the Fund’s Preferred Provider Plan Network THAT IS NOT a Value-Based Site <i>Designated</i> Hospital	
Billed Charge	\$52,000	Billed Charge	\$65,000
Negotiated Rate	\$30,000	Negotiated rate	\$52,000
Maximum Plan Allowance (MPA)	\$30,000	Maximum Plan Allowance	\$30,000
Amount over MPA	\$0	Amount over MPA	\$22,000
20% of \$15,000 (your coinsurance)	\$3,000	20% of \$15,000 (your coinsurance)	\$3,000
You owe over MPA	\$0	You owe over MPA	\$22,000
Total you owe	\$3,000	Total you owe (\$3,000 + \$22,000)	\$25,000

Travel-Related Expenses if you use a Designated Hospital

If you must travel 50 or more miles from your home to a Designated Hospital (a Value-Based Site) for routine total hip or knee replacement surgery, you may be entitled to reimbursement of up to \$750 for travel-related expenses. Call the Trust Fund Office for further information.

The Future Moms’ Program – Active Benefit Only Call 1 866 664 5404

This section about the Future Moms’ program is for female Active Participants or the spouse of an Active Participant. Dependent children are not covered for pregnancy-related expenses except for those mandated under the ACA Preventive Care Services.

Labor and Delivery charges are subject to a “Copayment” (see page 64). You have the ability to waive the Copayment by registering and participating throughout your pregnancy in the Future Moms’ program. The program is designed to identify pregnancy risks early in your pregnancy so you get the quality care you need to have a successful pregnancy and deliver a healthy baby.



Call the Future Moms’ program as soon as you know you are pregnant but no later than the first trimester (12 weeks) to register with the program. One of the registered nurses will explain the program benefits to you and help you get started. Some of the features of the program include:

- A toll-free telephone number where you can speak with a nurse coach anytime, any day about your pregnancy;

- Screenings to see if you might be at risk for depression or early delivery; **and**
- Useful tools to help you, your doctor and your Future Moms' nurse coach manage your pregnancy.

The Utilization Review (UR) Requirement

Call 1 800 274 7767

Utilization Review is required for all overnight inpatient hospitalizations. Exception: Maternity admissions where the length of stay does not exceed 48 hours for a routine delivery or 96 hours for a caesarean section are not subject to this requirement. If a maternity stay exceeds these time frames, then a Concurrent or Retrospective Review is required.

The Plan's Utilization Review (UR) program differs from the Plan's Pre-Authorization Review program.

- Utilization Review (UR) determines whether an **inpatient** hospitalization (where you will stay overnight as a bed patient) is Medically Necessary and for how many days.
- A Pre-Authorization Review, on the other hand, determines the Medical Necessity for the "procedure"—whether it is for a surgical procedure, diagnostic imaging procedures or any other non-emergency procedures listed on page 58.

**The Trust Fund's Professional Review Organization (PRO)
For Utilization Review for inpatient hospitalizations is through Anthem Blue Cross
1 800 274 7767**

There are three (3) different types of UR:

1. **Pre-Admission Review**
For all elective inpatient Hospital admissions
2. **Concurrent Review**
For any inpatient Hospital admission
3. **Retrospective Review**
After you have been discharged from the Hospital when there has been no Pre-Admission or Concurrent Review

Elective Inpatient Admissions

If you or an eligible Dependent are admitted to a Hospital on an elective basis, where you will stay overnight as a bed patient, you must obtain a Pre-Admission Review from the Fund's PRO, Anthem Blue Cross. If you do not obtain a Pre-Admission Review for an elective admission, you are responsible for the payment of an additional 20% of the 1st \$10,000 of Covered Charges - this amount is in addition to your Plan Year Deductible and the usual coinsurance. **This additional coinsurance will not apply when you use a Participating Hospital for inpatient services.**

If no Pre-Admission, Concurrent or Retrospective Review has taken place, and the Fund's PRO, Anthem Blue Cross, indicates that any days of inpatient hospitalization were not Medically Necessary, you will also be responsible for the payment of all Hospital charges for inpatient days determined to be not Medically Necessary in addition to your Deductible, the Plan's usual coinsurance and any extra coinsurance because a Pre-Admission Review was not performed. **These additional costs will not apply when you use a Participating Hospital**

Emergency Inpatient Admissions

If you are admitted to a Hospital on an emergency basis where you will stay overnight as a bed patient, a Concurrent or Retrospective Review by the Fund's PRO is required. You will be financially responsible for the payment of all Hospital charges for days of hospitalization determined by the PRO to be not Medically Necessary in addition to your Deductible and the Plan's usual coinsurance. **These additional costs will not apply when you use a Participating Hospital.**

Any additional amounts that you are required to pay because a Pre-Admission Review was not obtained prior to an elective admission or that you have to pay for days determined to be not Medically Necessary, do not count toward your Plan Year Out-of-Pocket Maximum.

Copayments, Deductible and Coinsurance

If you are a Retired Participant or the Dependent of a Retired Participant who is Eligible for Medicare, this section does not apply. See pages 45-47 for an outline of benefits in connection with Covered Expenses for Retired Participants and Dependents Eligible for Medicare.

Generally, you will share with the Fund the cost of Covered Expenses for yourself and your eligible Dependents. However, be sure you understand the “**Maximum Plan Allowance (MPA)**” table on page 52. Some Covered Expenses are limited to a maximum dollar allowable to which the coinsurance generally applies and **not the Hospital or provider’s actual billed charge**.

Covered Expenses that exceed the **Maximum Plan Allowance (MPA)**, **Allowed Charge** or **Covered Charges** are your responsibility to pay in addition to any Copayments, Deductible and coinsurance and do not count toward your Plan Year Out-of-Pocket Maximum.

The “terms” you will see when you share the cost of Covered Expenses with the Fund are:

1. Copayment;
2. Deductible; and
3. Coinsurance

These terms are frequently used when the Trust Fund Office communicates with you and your Dependents about your benefits.

Remember, some Covered Expenses require that you obtain a **Utilization Review (UR)**, a Pre-Authorization Review, use a Participating Hospital or Participating Provider from the Fund’s Preferred Provider Plan network or use a Value-Based Site if you live in California in order to receive full Plan benefits and limit your share of the cost for Covered Expenses.

Copayments

Always refer to the most recent Comparison of Benefit Plans for current Copayment information.

A Copayment is a flat dollar amount you pay for Covered Expenses and is in addition to the Plan Year Deductible and the coinsurance. Generally, you pay the Copayment at the time of the service and your Copayments do not count toward your Plan Year Deductible.

In general, you and your Dependents will have a Copayment for the following Covered Expenses:

1. Physician Office Visits: \$20 Copayment
 - Does not apply to:
 - ACA Preventive Care Services when you use a Participating Provider;
 - Chiropractic visits;
 - Routine Physical Examinations; **or**
 - Physician consultations.

2. Emergency Room Services: \$100 Copayment

- Does not apply if:
 - You are admitted to the Hospital as a bed patient where you will stay overnight;
 - You are transported to the emergency room by paramedic intervention; **or**
 - You are 1) dead upon arrival or 2) you die while being treated in the emergency room.

3. Labor and Delivery: \$1,000 Copayment¹

- The Copayment is waived if you register and participate throughout your pregnancy in the Future Moms' Program (see page 60).

Footnote 1. The Labor and Delivery Copayment applies only to the Active Benefits and only for a female Active Participant or the spouse of an Active Participant. The Labor and Delivery Copayment does not apply to Retired Benefits. Pregnancy related services are not covered for Dependent children of either an Active or Retired Participant unless required under ACA Preventive Care Services.

Deductible

Always refer to the most recent Comparisons of Benefit Plans for current Deductible information.

The Deductible is an annual amount that you pay for Covered Expenses before the Plan begins paying benefits. The Deductible accumulates during a Plan Year which is January through December.

Any part of the Deductible that you or your Dependents satisfy during the last three months of the Plan Year (October, November and December) will count towards the Deductible for the next Plan Year.

Active Participants and Eligible Dependents

There are two different Deductible "plans" for Active Participants. If you are an Active Participant, you and your spouse, if any, choose the Deductible by deciding whether or not to participate in the Healthy Structures Promise program (see page 56). When you and your spouse, if any, participate in the annual Promise program and follow through with all of the program requirements, the Deductible for you and your eligible Dependents will be lower. The two different Deductible Plans are described below.

1. **Basic Deductible Plan:** \$1,000 per individual/\$3,000 family maximum. This is the Deductible you and your eligible Dependents will pay for Covered Expenses if you and your spouse, if any, **choose not to participate** in the Healthy Structures Promise Program; **or**
2. **Premier Deductible Plan:** \$300 per individual/\$900 family maximum. This is the Deductible you and your eligible Dependents will pay for Covered Expenses if you and your spouse, if any, choose to participate in the Healthy Structures Promise Program.

The Deductible for Active Participants and Dependents will not apply to:

- ACA Preventive Care Services when you use a Participating Provider; or
- Routine Physical Examinations.

Retired Participants and Eligible Dependents

1. \$300 per individual/ \$900 family maximum

The Deductible for Retired Participants and Dependents will not apply to:

- Physician Office Visits when you use a Participating Provider;
- ACA Preventive Care Services when you use a Participating Provider; or
- Routine Physical Examinations.

NOTE: Amounts applied to your Plan Year Deductible, Plan Year Out-of-Pocket Maximum or benefits with dollar, quantity or frequency limitations, including, but not limited to, chiropractic care and hearing aids, will apply and accumulate separately for periods of coverage as an Active Participant and Dependent from periods of coverage as a Retired Participant and Dependent.

Family Deductible

The Family Deductible limits the amount of Deductible expense you and your Dependents have to pay during any one Plan Year for Covered Expenses.

Examples of a Family Deductible

If there are 4 or more Eligible Individuals in your family, the Family Deductible can be satisfied in any combination. **However, no one person can satisfy more than the individual amount.** See the example below.

Examples of Family Deductible

Active Premier Plan or Retired Not Eligible for Medicare \$300 per individual/\$900 family maximum				Active Basic Plan \$1,000 per individual/\$3,000 family maximum			
Example 1		Example 2		Example 1		Example 2	
You	\$100	You	\$100	You	\$1,000	You	\$1,000
Spouse	\$200	Spouse	\$200	Spouse	\$1,000	Spouse	\$ 500
Child A	\$300	Child A	\$300	Child A	\$ 500	Child A	\$ 500
Child B	\$300	Child B	\$200	Child B	\$ 500	Child B	\$ 500
		Child C	\$100			Child C	\$ 500
TOTAL	\$900		\$900	TOTAL	\$3,000		\$3,000

Coinsurance

Always refer to the most recent Comparisons of Benefit Plans for current coinsurance information.

The term “coinsurance” means an amount represented as a percentage that the Fund pays and that you pay on most Covered Expenses.

Generally, the coinsurance is 80/20 when you use a Participating Hospital or Participating Provider meaning that the Fund pays 80% and you pay 20% however, there are some exceptions which are outlined below and on the next pages.

- **The Fund pays its portion of the coinsurance only after you have paid any applicable Copayment and/or Deductible (some exceptions apply).**
- **The coinsurance that the Fund pays is based upon the lower of 1) the negotiated rate; 2) the Maximum Plan Allowance (MPA); or 3) the Allowed Charge.**

Hospital Charges for Outpatient Services

The following surgical procedures are limited to a Maximum Plan Allowance (MPA) when you have them performed at the outpatient department of a Hospital and **you live within California**. When **Hospital charges** exceed the MPA, you are responsible for payment of all **Hospital charges** that exceed the MPA in addition to your Deductible and the Plan’s usual coinsurance. Use a Value-Based Site instead if you live in California, i.e. an Ambulatory Surgical Center (ASC).

- **Arthroscopy procedures: \$6,000**
- **Cataract procedures: \$2,000**
- **Colonoscopy procedures (non-routine): \$1,500**

IMPORTANT: For surgical procedures that have a Maximum Plan Allowance (MPA), the MPA only applies to Hospital charges; it does not apply to the professional fees charged by the surgeon or any other non-Hospital related expenses in connection with the surgical procedure.

Participating Hospitals:

- The Fund will pay 80% of the negotiated rate **or** if you live within California, 80% of the Maximum Plan Allowance (MPA), **whichever is lower;**
- You will pay 20% of the negotiated rate **or** if you live within California, 20% of the Maximum Plan Allowance (MPA), **whichever is lower; plus**
- You will be responsible for payment of all **Hospital charges** that exceed the Maximum Plan Allowance (MPA) if you live within California and you have not met the criteria for an exception to the MPA.

Non-Participating Hospitals:

- The Fund will pay 50% of the Allowed Charge **or if you live within California**, 50% of the Maximum Plan Allowance (MPA), **whichever is lower;**
- You will pay 50% of the Allowed Charge **or if you live within California**, 50% of the Maximum Plan Allowance (MPA) **whichever is lower; plus**
- You will be responsible for payment of all **Hospital charges** that exceed the Allowed Charge or if you live in California, the Maximum Plan Allowance (MPA).

Hospital Emergency Room Services for an Emergency Medical Condition:

- The Fund will pay 80% of the Allowed Charge and you will pay the remaining charges.

Hospital Charges for Inpatient Services

IMPORTANT NOTE: The coinsurance information that follows for Hospital inpatient services does not apply to routine total hip or knee replacement surgery if you live within California. Use only a California based Designated Hospital that is part of the Fund's Preferred Provider Plan network for routine total hip or knee replacement surgery if you live in California.

Participating Hospitals:

- The Fund will pay 80% of the first \$15,000 of the Hospital's negotiated rate; and 100% of the Hospital's negotiated rates thereafter for charges that exceed \$15,000; **and**
- You will pay 20% of the first \$15,000 of the Hospital's negotiated rate.

Non-Participating Hospitals:

The term "**Covered Charges**" when you use a Non-Participating Hospital for an overnight stay means:

1. The Hospital's lowest semi-private room **or** ICU room rates; **or**
 2. 80% of the Hospital's lowest private room rate.
- The Fund will pay 50% (80% if inpatient admission is due to an emergency **or** you do not live in a Preferred Provider Plan Service Area) of the first \$15,000 of **Covered Charges** and 100% of **Covered Charges** thereafter that exceed \$15,000;
 - You will pay 50% (20% if due to an emergency **or** you do not live in a Preferred Provider Plan Service Area) of the first \$15,000 of **Covered Charges; plus**
 - You will be responsible for payment of all amounts that exceed **Covered Charges**.

- **Inpatient Hospital charges for routine total hip or knee replacement surgery are limited to Maximum Plan Allowance (MPA) of \$30,000 if you live in California.**

Participating Hospitals:

- The Fund will pay 80% of the first \$15,000 of the Hospital's negotiated rate and 100% of the Hospital's negotiated rate thereafter **up to the \$30,000 Maximum Plan Allowance (MPA)**;
- You will pay 20% of the first \$15,000 of the Hospital's negotiated rate; **plus**
- You will pay for all charges that exceed the MPA.

Non-Participating Hospitals:

- The Fund will pay 50% of the first \$15,000 of **Covered Charges** and 100% of **Covered Charges** thereafter **up to the \$30,000 Maximum Plan Allowance (MPA)**;
- You will pay 50% of the first \$15,000 of **Covered Charges**; **plus**
- You will pay all charges that exceed the MPA.

IMPORTANT: For surgical procedures that have a Maximum Plan Allowance (MPA), the MPA only applies to Hospital **charges**; it does not apply to the professional fees charged by the surgeon or any other non-Hospital related expenses in connection with the surgical procedure.

Other Covered Expenses (Non-Hospital)

Remember, you must pay any applicable Copayment and Deductible first (some exceptions may apply).

Participating Providers:

- Generally, the Fund will pay 80% of the negotiated rate;
- You will pay 20% of the negotiated rate; **plus**
- You will be responsible for payment of all amounts that exceed the Maximum Plan Allowance (MPA).

Exceptions:

- The Fund will pay 100% of the negotiated rate (after the Copayment and Deductible) for Physician Office Visits for Active Participants and Dependents.
- The Fund will pay 100% of the negotiated rate (after the Copayment) for Physician Office Visits for Retired Participants and Dependents.
- The Fund will pay 100% for ACA Preventive Care Services (no Copayment or Deductible).

For a complete list of Preventive Care Services that the Plan will cover with no cost sharing when you use a Participating Provider (some on this list may be covered under the Drug Benefit, where applicable) visit: www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

- The Fund will pay up to 100% of the negotiated rate (less the Deductible unless otherwise indicated) but not to exceed the **Maximum Plan Allowance** (MPA) for the following Covered Expenses: (see page 52 for the MPA amounts)
 - Routine Physical Examinations (no Copayment or Deductible);
 - Hearing Aids;
 - Chiropractic visits (no Copayment);
 - Chiropractic X-Rays;
- You will be responsible for payment of all amounts that exceed the **Maximum Plan Allowance** (MPA).

Non-Participating Providers:

- Generally, the Fund will pay 50% of the Allowed Charge;
- You will pay 50% of the Allowed Charge; **plus**
- You will be responsible for payment of charges that exceed the Allowed Charge or the **Maximum Plan Allowance** (MPA).

Exceptions:

- The Fund will pay up to 100% of billed charges (less the Deductible unless otherwise indicated) but not to exceed the **Maximum Plan Allowance** (MPA) for the following Covered Expenses: (see page 52 for the MPA amounts)
 - Routine Physical Examinations (no Copayment or Deductible);
 - Hearing Aids;
 - Chiropractic visits (no Copayment);
 - Chiropractic X-Rays;
 - Ambulatory Surgical Centers; **and**
- You will be responsible for payment of all amounts that exceed the **Maximum Plan Allowance** (MPA).

Payment of Benefits

Claims must be received by the Fund's designee Anthem Blue Cross (ABC), or in the case of the **BlueCard PPO** national network, the host plan, as soon as possible but in no event later than one year from the date of services. Claims should not be sent to the Trust Fund Office. If you do send them to the Trust Fund Office, the processing of the Claims will be delayed.

Once a Claim is processed by the Fund, you will receive an Explanation of Benefits (EOB) notice. The EOB provides you with an overview of how the Claim was processed, i.e., how much was credited to your annual Plan Year Deductible, your Copayment, if any; how much was paid, if any, to the provider and how much is your responsibility to pay and the amount that was credited to your Plan Year Out-of-Pocket Maximum

Plan Year Out-of-Pocket Maximum

An important cost-saving feature of the Plan is the annual Plan Year **Out-of-Pocket Maximum**. The Plan Year Out-of-Pocket Maximum limits *your share of cost* on your health care expenses each Plan Year.

What Counts Toward the Plan Year Out-of-Pocket Maximum?

Generally:

1. Copayments;
2. Deductible; **and**
3. Coinsurance

Only when you use Participating Hospitals and Providers from the Fund's Preferred Provider Plan Network.

**The Plan Year Out-of-Pocket Maximum:
\$3,000 per individual, \$6,000 family maximum**

What Does Not Count Toward the Plan Year Out-of-Pocket Maximum?

1. All Copayments, Deductible and coinsurance you pay **when you use a Non-Participating Hospitals or Non-Participating Providers with the exceptions indicated on the next page.**
2. All charges that exceed a Plan maximum, including but not limited to:
 - Charges that exceed the Maximum Plan Allowance (MPA), the Allowed Charge or Covered Charges;
3. Services and supplies that are not covered by the Plan;
4. Penalties for non-compliance with the Utilization Review (UR) and the Pre-Authorization Review programs;

5. Balance billing;
6. Dental and vision expenses, including, but not limited to, copayments, deductibles and expenses in excess of the benefits provided under the separate dental and vision programs;
and
7. Drug Benefit regular copayments (see Plan Year Out-of-Pocket Maximum for the Plan's Drug Benefit on page 77).

Exceptions:

1. If you use a Non-Participating Hospital for outpatient Emergency Services for an Emergency Medical Condition, any Copayment, Deductible and/or coinsurance you pay will count toward the Plan Year Out-of-Pocket Maximum;
2. If you use a Non-Participating Hospital for an inpatient emergency admission to a Hospital, any Deductible and/or coinsurance will count toward the Plan Year Out-of-Pocket Maximum; **or**
3. If you use a Non-Participating Hospital for inpatient Hospital services because you do not live within the Fund's Preferred Provider Plan Service Area, any Deductible and/or coinsurance you pay will count toward the Plan Year Out-of-Pocket Maximum.

Once the **Plan Year Out-of-Pocket Maximum** for the Plan Year has been reached, either individually or as a family, the individual, (or the family, if the family maximum has been reached), will have no further Copayments, Deductible and/or coinsurance for the remainder of the Plan Year when you use Participating Hospitals or Participating Providers.

Drug Benefit

Glossary of Terms

Contracting Pharmacy	Means a pharmacy which has a contract with the <u>Pharmacy Benefit Manager (PBM)</u> to provide prescription drug services to Eligible Individuals.
Formulary For Active Participants/Dependents and Retired Participants/Dependents not Eligible for Medicare	Means a list of cost-effective outpatient prescription drugs, with preferential pricing; primarily generic with some brand-name Drugs included, for treating various classes of conditions. Drugs not on the Formulary list are not covered by the Plan.
Formulary For Retired Participants and Dependents Eligible for Medicare	Means a list of outpatient prescription drugs, with preferential pricing. You pay a higher copayment when you purchase Covered Drugs not on the Formulary list (a non-Formulary Drug).
Non-Contracting Pharmacy	Means a pharmacy that does not have a contract with the <u>Pharmacy Benefit Manager (PBM)</u> to provide prescription Drug services to Eligible Individuals.
Pharmacy Benefit Manager (PBM)	Means the company under contract with the Cement Masons Health and Welfare Trust Fund for Northern California and who administers the Direct Payment Plan's prescription Drug benefits.
Preventive Care Services	Means medications mandated by the <u>Affordable Care Act (ACA)</u> that are required to be covered with no cost-sharing when you use a Contracting Pharmacy.
Specialty Pharmacy	Means a pharmacy that provides medications that may be self-administered or administered at a Physician's office to treat a chronic or an acute illness. The Specialty Pharmacy manages specialty medications that often times are not available at the local retail Contracting Pharmacy because they may require special handling and storage. The Specialty Pharmacy is through the PBM.

The Pharmacy Benefit Manager (PBM) – OptumRx

The Fund's contracting Pharmacy Benefit Manager (PBM) is OptumRx.

OptumRx contracts with various retail pharmacies throughout the United States. Most large chain pharmacies are in the OptumRx network. However, **BEFORE** you have your prescription filled, you should always ask the pharmacy if they are a Contracting Pharmacy with OptumRx. You can also register with a user name and password on the OptumRx website to check for contracting pharmacies.



Maintenance Medications are medications you take on a regular basis.

When you purchase maintenance medications from a retail Contracting Pharmacy, beginning with the 4th fill of **any one medication**, the usual copayment **will double for the same 30-days' supply**. You may wish to consider using the Mail Service Pharmacy through OptumRx for additional refills. For the same double copayment you pay at the retail Contracting Pharmacy, you **can receive up to a 90 days' supply instead of 30 days' supply when you fill your medications through the Mail Service Pharmacy**.

Mail Service Pharmacy

If you wish to take advantage of the Mail Service Pharmacy, after your 3rd fill at the retail Contracting Pharmacy and at least three weeks prior to the 4th fill, you should ask your prescribing Physician to call or fax your prescription order to OptumRx. You should then follow up with a telephone call to OptumRx to tell them how you wish to pay for your copayments (FDA approved generic contraceptives for female Participants and/or female eligible Dependents do not have a copayment).

Formulary Drugs

For Active and Retired Participants and Dependents Who Are Not Eligible for Medicare:

Your prescribing Physician **must select a Covered Drug from the Plan's Formulary list**.

Generally, Drugs that are not on the Plan's Formulary list are not covered.

However, there may be circumstances where there is no suitable Drug on the Plan's Formulary list to treat your specific illness. If this happens, the prescribing Physician must obtain a prior authorization for the "non-Formulary" Drug. The Physician's request should be made to OptumRx. Medical evidence must be presented to demonstrate that there is no suitable Drug from the Plan's Formulary list. If your request has been denied, you may file an appeal with the Fund through the Plan's Internal Appeals process. See Claims and Appeals section beginning on page 84.

For Retired Participants and Dependents Who Are Eligible for Medicare:

Your Physician may prescribe a Covered Drug that is not on the Formulary list but you will pay a higher copayment.

Covered Drug Expenses

Covered Drug Expenses include:

- Drugs prescribed by a Physician licensed by law to administer or prescribe Drugs;
- Drugs, insulin or insulin injection kits:
 - Which are supplied to the patient in the Physician's office, and for which a charge is made separately from the charge for any other item or expense, **or**

- Which are supplied by a Hospital for use outside of the Hospital provided that the Drugs are prescribed by a Physician licensed by law to prescribe or administer Drugs.
- Compounding dermatological preparations prescribed by a Physician;
- Therapeutic vitamins, cough mixtures, antacids, eye and ear medications prescribed by a Physician for the treatment of a specific illness or complaint and other over-the-counter Drug required under ACA (you must have a prescription from your Physician);
- FDA approved generic (or brand-name when a generic is not appropriate) contraceptives, defined under Preventive Care Services; (covered with no cost sharing when you use a Contracting Pharmacy including the Mail Service Pharmacy);
- Self-administered oral or injectable medications to treat a chronic or acute condition, which can safely be administered in the patient's home. If the medication is included on the Plan's list of specialty medications and requires ongoing clinical supervision, the medications must be obtained from and distributed under a program managed by the Plan's Specialty Pharmacy. Self-administered injectables, such as insulin and Imitrex® are not specialty medications requiring distribution from the Fund's Specialty Pharmacy; these can be obtained from a retail Contracting or Non-Contracting Pharmacy; **and**
- The following injectable medications: Ana-Kits, Epi-Pens, Glucagon and Imitrex®.

Excluded Drugs

- Non-Formulary Drugs for Active and Retired Participants and Dependents who are not Eligible for Medicare. Under certain circumstances, you may be entitled to receive a Drug not on the Formulary list but you must have a prior authorization from the Fund's PBM;
- Drugs taken or administered while a patient is in a Hospital (covered as part of the Hospital inpatient or outpatient charges);
- Patent or proprietary medicines not requiring a prescription, **except** insulin and those over-the-counter Drugs prescribed (require a prescription) by a Physician in accordance with the ACA Preventive Care Services;
- Appliances, devices, bandages, heat lamps, braces or splints (may be a Covered Expense under the hospital-medical plan);
- Multiple non-therapeutic vitamins, cosmetics, dietary supplements, health and beauty aids **except** as may be prescribed by a Physician under ACA Preventive Care Services;
- Charges for prescriptions in excess of a 30-days' supply at a Retail pharmacy or a 90-days' supply from the Mail Service Pharmacy; **and**
- ACA mandated Preventive Care Services **when purchased or administered by a non-Contracting Pharmacy.**

If You Use a Non-Contracting Pharmacy

If you use a Non-Contracting Pharmacy to purchase any Covered Drug, you must pay the full cost of your medications at the time of purchase. You will then need to file a Claim with OptumRx for reimbursement. Reimbursement will be based on the contract rate that would have been paid to a Contracting Pharmacy. In most cases, you will pay a higher share of the cost for Covered Drugs when you use a Non-Contracting Pharmacy.

Drug Benefit Copayments

Preventive Care Services:

The new health care law requires that this Plan provide coverage for you and your eligible Dependents for certain Drugs with no cost sharing when those Drugs are prescribed by your Physician and are purchased through the Fund's Pharmacy Benefit Manager's (PBM) Contracting Pharmacy or Mail Service Pharmacy. To see what is covered, visit:

www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

No Copayment when you use a Contracting Pharmacy or the Mail Service Pharmacy for:

- All FDA approved **generic** contraceptives for female Participants and female eligible Dependents (brand-name is covered only when a generic is not medically appropriate).

No Copayment when you use a Contracting Pharmacy for:

- Certain Over-the-Counter (OTC) Drugs required under ACA and that are prescribed by a Physician.

No Copayment when you use a Contracting Pharmacy for:

- Flu and Shingles vaccinations

All other Drug Copayments

Your Regular Copayments (Covered Drugs only from the Formulary List) Active and Retired Participants and Dependents not Eligible for Medicare		
If you use an OptumRx Contracting Pharmacy	If you do not use an OptumRx Contracting Pharmacy	If you use the OptumRx Mail Service Pharmacy
<p><u>Formulary generic Drugs</u> A \$10 regular copayment for up to a 30 days' supply for the 1st through the 3rd fill ¹</p>	<p>You pay the full cost at the pharmacy and submit a Claim to OptumRx. You will be reimbursed based upon the contract rate for a Contracting Pharmacy less any applicable copayment or other costs</p>	<p><u>Formulary generic Drugs</u> A \$20 regular copayment for up to a 90-days' supply</p>
		<p><u>Formulary brand-name Drugs</u> ² A \$50 regular copayment for up to a 90-days' supply</p>
<p><u>Formulary generic Drugs</u> ² A \$20 regular for up to a 30-days' supply beginning on the 4th fill ¹</p>		
<p><u>Formulary brand-name Drugs</u> ² A \$25 regular copayment for up to a 30-days' supply for the 1st through the 3rd fill ¹</p>		
<p><u>Formulary brand-name Drugs</u> ² A \$50 regular copayment for up to a 30-days' supply beginning with the 4th fill ²</p>		
Non-Formulary brand-name Drugs are not covered ³		
Your Regular Copayments (Covered Drugs) Retired Participants and Dependents Eligible for Medicare		
If you use an OptumRx Contracting Pharmacy	If you do not use an OptumRx Contracting Pharmacy	If you use the OptumRx Mail Service Pharmacy
<p><u>Generic Drugs</u> A \$10 regular copayment for up to a 30-days' supply for the 1st through the 3rd fill ¹</p>	<p>You pay the full cost at the pharmacy and submit a Claim to OptumRx. You will be reimbursed based upon the contract rate for a Contracting Pharmacy less any applicable copayment or other costs</p>	<p><u>Generic Drugs</u> A \$20 regular copayment for up to a 90-days' supply</p>
<p><u>Generic Drugs</u> A \$20 regular copayment for up to a 30-days' supply beginning with the 4th fill</p>		<p><u>Formulary brand-name Drugs</u> ² A \$50 regular copayment for up to a 90-days' supply</p>
<p><u>Formulary brand-name Drugs</u> ² A \$25 regular copayment for up to a 30-days' supply for the 1st through the 3rd fill ¹</p>		<p><u>Non-Formulary brand-name Drugs</u> ² A \$100 regular copayment for up to a 90-days' supply</p>
<p><u>Formulary brand-name Drugs</u> ² A \$50 regular copayment for up to a 30-days' supply beginning with the 4th fill ¹</p>		
<p><u>Non-Formulary brand-name Drugs</u> ² A \$50 regular copayment for up to a 30-days' supply for the 1st through the 3rd fill ¹</p>		
<p><u>Non-Formulary brand-name Drugs</u> ² A \$100 regular copayment for up to a 30-days' supply beginning with the 4th fill ¹</p>		

See footnotes on the next page.

Footnote 1. Beginning with the 4th fill of any one medication, your regular copayment will double for the same 30-days' supply. If you choose to use the OptumRx Mail Service Pharmacy for Covered Drugs you take on an ongoing basis (maintenance medications), for the same regular double copayment, you can receive up to a 90-days' supply of your medication.

Footnote 2. If there is a generic available and you choose a brand-name Drug instead, **in addition to your regular copayment**, you will also be responsible for paying the difference in cost between the generic and the brand-name Drug. The additional cost does not count toward your annual Out-of-Pocket Maximum for the Drug Benefits.

Footnote 3. For Active and Retired Participants and Dependents not Eligible for Medicare, if there is no suitable Drug from the Formulary list, your prescribing Physician can request a prior authorization from OptumRx for a Non-Formulary Drug.

Plan Year Out-of-Pocket Maximum for Covered Drugs

The annual Plan Year Out-of-Pocket Maximum for Prescription Drugs:

\$1,000 per individual, \$3,000 family maximum

What counts toward the Plan Year Out-of-Pocket Maximum for the Plan's Drug Benefits?

Only the **regular copayments** you pay at a Contracting Pharmacy and/or the Mail Service Pharmacy count toward the Plan Year Out-of-Pocket Maximum.

Third Party Liability

If you or an eligible Dependent suffers an injury or illness that was caused by a third party, you must agree to pursue your Claim against the responsible third party.

Before the Plan pays for any Covered Expenses in connection with that illness or injury, you or your eligible Dependent, must agree, **in writing**, to reimburse the Fund for the benefits paid on your behalf. This reimbursement will come from the money received as a result of pursuing a Claim against a third party or any insurance company.

If you fail to complete the required documents or cooperate with the Board in pursuing the responsible third party, your Claim for benefits may be denied. Under the reimbursement agreement, the Fund has an automatic equitable lien against any recovery you receive from the responsible third party. If you fail to honor that lien or impair the Fund's right to recover from the money you receive, the Fund has the right to file suit in federal court to recover the amount of the benefits paid on your behalf. Your obligation to reimburse the Fund will arise if you receive money by way of a judgment, arbitration award, settlement or otherwise in connection with, or arising out of, any Claim for or your right to damages regardless of how classified, for your injury or illness for which a third party is responsible. This includes payments from the third party, the third party's insurer or other indemnitor or from your uninsured or under-insured motorist coverage. In addition, the reimbursement to the Fund will not be subject to the common fund doctrine, the make-whole doctrine and any reduction based on comparative fault.

Benefits Required by Law

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurers may not restrict benefits for any Hospital length of stay for the mother or newborn child to less than 48 hours following a normal delivery, or to less than 96 hours following a caesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the 48 hours, or 96 hours stay as applicable.

ACA Mandated Benefits

The new federal health care law, the Patient Protection and Affordable Care Act, also known as the "Affordable Care Act (ACA)", requires that all non-grandfathered health plans, such as the Cement Masons Health and Welfare Plan for Northern California provide certain benefits under the Plan. For a complete list of ACA mandated benefits, visit:

www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

Women's Health and Cancer Rights Act (WHCRA)

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must also provide benefits for reconstructive surgery, in a manner determined in consultation with the attending physician and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the Plan's Copayment, Deductible and coinsurance provisions.

In addition to the information concerning Women's Health and Cancer Rights Act (WHCRA) appearing in this booklet, the Plan is required to mail an annual notice to remind you that breast cancer patients who elect to have reconstructive surgery in connection with a mastectomy have certain protections under federal law.

Exclusions, Limitations and Reductions

The Fund will not provide benefits for charges, services, treatment or supplies related to or in connection with:

1. Hospital, medical and/or Drugs that are not Medically Necessary for the care and treatment of a bodily injury or illness or for the pregnancy of an eligible female Participant or the spouse of a Participant;
2. Covered Expenses that are in excess of the Maximum Plan Allowance (MPA) or the Allowed Charge;
3. Any accidental bodily injury arising out of, or in the course of, the Eligible Individual's employment **or** in connection with an illness for which the Eligible Individual is entitled to indemnity under the provisions of any Workers' Compensation or similar law;
4. Confinements in or treatment by a Veterans Administration (VA) Hospital, **or** for care or treatment obtained from any federal, state or local governmental agency or program where the care or treatment is available without cost to the Eligible Individual, except to the extent the law requires benefits to be paid by the Fund;
5. Confinement or care obtained in a Hospital owned or operated by any federal, state or local governmental agency or program, unless there is an unconditional requirement that the Eligible Individual pay for the confinement or care, without regard to any rights against others, contractual or otherwise;
6. Conditions caused by or arising out of an act of war, armed invasion or aggression;
7. A condition for which the Eligible Individual is not under the care of a Physician, or for a period of confinement beyond that authorized by the Professional Review Organization (PRO);
8. Eye refractions or eyeglasses (may be covered under a separate vision plan);
9. Callus or corn paring; toenail trimming; treatment of chronic conditions of the foot such as weak or fallen arches, flat or pronated foot metatarsalgia, or foot strain;
10. Expenses rendered or provided outside of the United States, its Territories, and Possessions, except for treatment for a life-threatening emergency which, without immediate intervention, would result in placing the Eligible Individual's health in serious jeopardy or serious impairment to bodily functions or serious dysfunction of any bodily part. Some examples of life threatening conditions requiring emergency care include, but are not limited to, heart attacks, strokes, poisoning and appendicitis;
11. Obesity or weight control, except as outlined on page 50, Covered Expenses #12. This exclusion does not apply to screening and counseling by a Participating Provider in accordance with ACA Preventive Care Services;

12. Infertility as defined by the American College of Obstetrics and Gynecology, including, but not limited to, in vitro fertilization, artificial insemination, surgery, including treatment to alleviate pelvic adhesions (unless determined to be Medically Necessary) and other infertility related services, including charges to reverse voluntary or surgically induced infertility;
13. Experimental or Investigative Procedures except as outlined on page 7;
14. Intentionally self-inflicted injury, or injury or illness resulting from participating in, or in consequence of having participated in, the commission or attempted commission of an assault or felony, unless the injury or illness is the result of domestic violence or is the direct result of an underlying health factor;
15. Cosmetic surgery, including procedures intended to reduce breast size **except for** cosmetic surgery which is not primarily for beautification but is performed in connection with the Women's Health and Cancer Rights Act (see page 79);
16. Pregnancy of a Dependent child, unless covered by law as Preventive Care Services;
17. Pregnancy of an Eligible Individual functioning as a surrogate, or any person functioning as a surrogate to an Eligible Individual. This includes, but it not limited to, prenatal care, labor/delivery and postnatal services of the surrogate;
18. Dental appliances, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth of gums, **except** as outlined on page 50, Covered Expenses #15;
19. Sexual reassignment including, but not limited to, medications, implants, hormone therapy, surgery and medical care;
20. Travel expense except in connection with using a Value-Based Site for routine hip or knee replacement surgery that is 50 or more miles from the Eligible Individual's home;
21. An institution that is primarily a rest home, home for the aged, a nursing home, a convalescent home or any institution of similar character providing Custodial Care;
22. Ambulance transportation that is primarily for the convenience of the Eligible Individual or ambulance transportation by railroad;
23. Services rendered or provided for which an Eligible Individual is not required to pay or which are obtained without cost or for which there would be no charge if the Eligible Individual receiving the treatment were not covered by the Fund;
24. **Covered Expenses** which are payable by Medicare for Retirees and Dependent who are Eligible for Medicare, whether or not the individual has actually enrolled in Medicare.

Other Insurance—Coordination of Benefits

This section is a summary of only a few of the provisions of the Plan to help you understand **coordination of benefits** (COB), which can be very complicated. This is not a complete description of all of the coordination rules and procedures and does not change or replace the language contained in the Plan Rules and Regulations. If this outline or overview does not answer your questions, call the Trust Fund Office for assistance or consult the Plan Rules and Regulations.

It is common for family members to be covered by more than one Group Plan. This happens for example when a both spouses work and choose to have family coverage.

When both you and your spouse have coverage under more than one Group Plan, the Fund must follow a procedure called “**coordination of benefits** (COB). COB determines how much each Group Plan should pay when you and your eligible Dependents have a Claim. The goal is to make certain that the combined payments of all Group Plans do not add up to more than covered health care expenses.

COB is complicated and covers a wide variety of circumstances. Below is an outline of some of the more common situations.

The Order of Benefit Determination—Primary or Secondary

The “order of benefit determination” means the order in which each Group Plan pays benefits, i.e. which plan pays first (primary); which plan pays second (secondary).

You will be asked to supply the Trust Fund Office with name of any other Group Plans that covers you and your eligible Dependents. The Trust Fund Office needs this information in order to determine the order in which the Group Plans pay benefits.

Any Group Plan that does not have a COB provision will always pay first as “primary” over any other Group Plan.

This Plan will be “primary” when any other provision of federal law requires it. In general, this Plan will be primary when:

- The Claim for Covered Expenses is for you, unless you are covered by Medicare **and** there is no other Group Plan for either you or your spouse **as an employee or Dependent**.
- The Claim for Covered Expenses is for your spouse, unless your spouse is covered by Medicare **and** does not have a Group Plan **as an employee or Dependent**.
- The Claim for Covered Expenses is for your eligible Dependent child, you are not divorced from the child’s other natural parent **and** your birth date (month and day) is earlier in the year than that of your spouse.
- The Claim for Covered Expenses is for your eligible Dependent child, you are divorced from the child’s other natural parent **and** there is a court order that makes it your responsibility to provide health plan coverage for the child; **or**

- There is no court order and you have custody of the child.

If you are a Retired Participant or a Dependent of a Retired Participant who is Eligible for Medicare, the order of benefit determination is based upon federal law:

- The Group Plan that covers you as an employee or a Dependent of the employee is primary;
- Medicare is secondary; **and**
- This Plan is last.

When the Fund is primary, benefits will be paid based on the terms of the Plan just as if you had no other Group Plan coverage.

When the Fund is not primary, it pays benefits after the other Group Plan coverage has paid.

If you need assistance understanding how coordination of benefits works with any other Group Plan you may have, call the Trust Fund Office for assistance.

Claims and Appeals Procedures for the Direct Payment Plan

Claims

This section describes the proper procedures to follow when filing a Claim for benefits and what to do if your Claim is denied.

What is a “Claim”?

A Claim is a request for Plan benefits made according to the Plan’s reasonable Claims procedures described in this section. A Claim can be a **“Pre-Service”, “Urgent Care”, “Concurrent” or “Post-Service Claim”**.

What is Not a “Claim”?

- Simple or general inquiries about the Plan’s provisions that are unrelated to any specific benefit Claim.
- Request for a determination regarding the Plan’s coverage of a medical treatment or service that your Physician has recommended, but that treatment or service has not yet been provided and the treatment or service is for non-urgent care that does not require prior authorization from the Plan. In this case, you may request a determination from the Trust Fund Office regarding the Plan’s coverage of the treatment or service. However, any determination from the Trust Fund Office is not a guarantee of payment because the request is not a Claim and, therefore, is not subject to the requirements and timelines of a “Claim.”
- Request for a prescription to be filled under the terms of the Plan is not a Claim under these procedures. If, however, your request for a prescription to be filled is denied, you are entitled to file a Claim and appeal the denial by using the procedures described in this section.

What is an “Adverse Benefit Determination”?

This is a denial, reduction or termination of a Claim or for the failure to pay for all or part of a Claim for benefits. Some examples of an Adverse Benefit Determination include, but are not limited to, the following:

- Payment of less than 100% of the benefit owed under the terms of the Plan;
- Denial or reduction in a benefit as a result of a Utilization Review or Pre-Authorization Review decision, network exclusion, or other Plan limitation;
- Failure to provide a benefit because the service or item is considered Experimental or Investigative, not Medically Necessary or not medically appropriate;
- Denial because the claimant is not considered eligible under the Plan; **or**

- The Rescission of coverage for benefits.

A Participating Provider (Physician, Hospital or other covered health care provider) or pharmacy that fails to provide a service or fill a prescription unless the Eligible Individual pays the entire cost is **NOT** an **Adverse Benefit Determination** if that refusal is based on the Plan's Rules and Regulations.

What is an “Independent Revue Organization (IRO)”?

This is an entity that will conduct an independent External Review of an Adverse Benefit Determination. The IRO will be required to follow the Plan's External Review procedures as well as any applicable federal regulations. For more information, see Appendix 1 on page 107.

What is a “Rescission” of Coverage?

A Rescission means the retroactive cancellation or termination of coverage for reasons other than fraud, misrepresentation or non-payment of premiums.

Claims Procedures

In most cases, your health care provider will submit a Claim on your behalf. If you require a Claim Form, you may obtain one from the Trust Fund Office or your health care provider can use a “universal claim form”.

What Must be Included on a Claim?

To be considered a “Claim”, your request for benefits must include the following information:

- Participant's full name;
- Patient's full name;
- Patient's date of birth;
- Participant's Health Plan ID number or Social Security Number;
- Date of Service;
- CPT code (the code for Physician services and other health care services found in the “Current Procedural Terminology, as maintained and distributed by the American Medical Association);
- ICD code (the diagnosis code found in the International Classification of Diseases Clinical Modification as maintained and distributed by the US Department of Health and Human Services (HHS));
- Billed charge (bills must be itemized, showing all dates of visits);
- Number of units (for example, anesthesia and certain other services);
- Federal Taxpayer Identification Number (TIN) of the provider;
- Provider's billing name, address, phone number and professional degree or license;
- Details of the accident if treatment is due to an injury; **and**
- Information of other insurance coverage, if any.

Types of Claims

Pre-Service Claims

A Pre-Service Claim is a Claim for benefits that requires approval by the Plan **before** medical care is obtained. Pre-approval will allow you to receive the maximum benefits available under the Plan. For example, if you are to be confined in a Hospital for an elective surgery, you or your Physician must arrange Utilization Review (UR); otherwise, you may be responsible for more out-of-pocket expenses.

When to File a Pre-Service Claim

Circumstances under which you should submit a Pre-Service Claim are listed below.

1. **Pre-Service Claims** for all:

- Elective, non-emergency Hospital admissions;
- Surgical treatment for morbid obesity;
- Hospice Care; and
- Home Health Care.

Where to file a Pre-Service Claim for #1 above

Call Anthem Blue Cross
1 800 274 7767

2. Pre-Service Claims for all non-emergency outpatient services for:

- Arthroscopy procedures;
- Cataract procedures;
- Colonoscopy procedures;
- MRI, CT and PET scans;
- Chemotherapy;
- Radiation therapy;
- Physical therapy;
- Sleep studies;
- **Durable Medical Equipment** (DME) of \$500 or more;
- All genetic testing; **and**
- Routine costs associated with an approved clinical trial.

Where to File a Pre-Service Claim for #2 above

Call the PHA Care Counselor
1 855 754 7271

Contact the Care Counselor or the Trust Fund Office to confirm that the health care provider is part of the Fund's Preferred Provider Plan network. If the surgical procedure is one where **Hospital charges** have been limited to a **Maximum Plan Allowance** (MPA) and you live within California, use only a Value-Based Site that is part of the Fund's Preferred Provider Plan; doing both will ensure you will receive the highest reimbursement by the Plan.

For a properly filed Pre-Service Claim, you and your health care provider will be notified of a decision within **15 days** from receipt of the Claim, unless additional time is needed to make a decision. If necessary, an extension of up to **15 days** may be required due to matters beyond the control of the Plan. You will be notified of the circumstances requiring an extension of time and the date a decision will be made available to you.

If an extension is necessary because additional information is required, the request will specify the information needed. In this case, you or your health care provider will have **45 days** from receipt of the notification to submit the additional information. If that information is not provided within **45 days**, your Claim will be denied. During the period in which you are allowed to provide additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until **45 days** have elapsed or the date you respond to the request, whichever occurs sooner. Once your response is received, the Plan has **15 days** to make a decision on a Pre-Service Claim.

If your health care provider does not file a Pre-Service Claim properly, you and your health care provider will be notified as soon as possible, but not later than **5 days** after receipt of the Claim. This notice will advise you of the proper procedures for filing the Claim. You and your health care provider will only receive notice of an improperly filed Pre-Service Claim if the Claim includes **1) your name, 2) your specific medical condition or symptom, and 3) a specific treatment, service or product for which approval is requested.** Unless the Claim is resubmitted properly, it will not constitute a "Claim" and will not be acted on.

Urgent Care Claims

An Urgent Care Claim is any Claim for medical care or treatment that, if handled within the time frames of a Pre-Service Claim as described above, could seriously jeopardize the life or health of the individual or his ability to regain maximum function or, in the opinion of the Physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot adequately be managed without the care or treatment in the Claim.

Where to File an Urgent Care Claim

Call Anthem Blue Cross for all Urgent Care Claims

1 800 274 7767

Urgent Care Claims are not to be submitted by U.S. Postal Service

Whether your Claim is an Urgent Care Claim is determined by Anthem Blue Cross by applying the judgment of a prudent layperson possessing an average knowledge of health and medical Claims processing. Any Claim made by a health care provider, who has knowledge of your medical condition and determines that it is an Urgent Care Claim will be treated as an Urgent Care Claim.

If you are requesting approval of an Urgent Care Claim, the response time differs, depending on whether your request contains sufficient information for making a determination. If the request contains sufficient information, Anthem Blue Cross will respond to you and your health care provider with a determination, by telephone, as soon as possible, taking into account the medical urgency of

the patient's condition, but not later than **72 hours** after receipt of the Claim by Anthem Blue Cross. The decision will be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or not benefits are covered or payable or to what extent benefits are covered or payable, Anthem Blue Cross will notify you and your health care provider as soon as possible, but not later than **24 hours** after receipt of the Claim, of the specific information necessary to complete the Claim. You or your health care provider must provide the specified information within **48 hours**. Notice of the decision will be provided no later than **48 hours** after the Plan receives the specified information, but only if the information is received within the required time frame. If the information is not provided within the time frame, your Claim will be denied.

Concurrent Claims

A Concurrent Claim is a Claim that is reconsidered after an initial approval was made and, after reconsideration, results in a reduction, termination or extension of a benefit. An example of a Concurrent Claim is an inpatient Hospital stay that was originally authorized for 5 days and is reviewed after 3 days to determine if the full 5 days is still appropriate. In this example, a decision to reduce, terminate or extend the inpatient Hospital stay is made concurrently with the provision of medical treatment. Reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of an approved benefit will be made by the Trust Fund Office or Anthem Blue Cross as soon as possible but, in any event, in time to allow you to appeal the decision before the benefit is reduced or terminated.

Any request by a claimant to extend approved urgent care treatment will be acted upon by Anthem Blue Cross within **24 hours** of receipt of the Claim, provided the Claim is received at least **24 hours** prior to the expiration of the approved treatment. A request to **extend** approved treatment that does not involve urgent care will be decided upon according to Pre-Service or Post-Service time frames, whichever apply.

Post-Service Claims

Claims that are not Pre-Service, Urgent Care or Concurrent are considered Post-Service Claims. An example of a Post-Service Claim is any Claim submitted for payment after medical services or treatment has been obtained.

Usually, you will be notified of the decision on your Post-Service Claim within **30 days** from the date the Plan receives your Claim. This period may be extended one time by the Plan for up to **15 days** if an extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial **30-day** period of the circumstances requiring the extension of time and the date by which the Plan expects to make its decision.

Where to File a Post-Service Claim

Post-Service Claims are considered “**filed**” as soon as they are electronically filed with Fund’s designee, Anthem Blue Cross, or the “host plan” under the **BlueCard PPO** national network. Claims not submitted electronically can be mailed to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

When Post-Service Claims should be filed

Post-Service Claims should be filed as soon as reasonably possible but in no event more than one year from the date of service.

Notice of Initial Benefit Determination

When you submit a Claim, you will be provided with **written** Notice of an Initial Benefit Determination (decision). If the decision is an “Adverse Benefit Determination”, your notice must include:

The identity of the Claim involved, including the date of service, the provider and the Claim amount;

Information concerning the diagnosis code, treatment code and what those codes mean which is available upon request and without charge;

The specific reason for the Adverse Benefit Determination, including the denial code and what the code means and the standards the Plan used in making the Adverse Benefit Determination;

The specific Plan provision on which the Adverse Benefit Determination is based;

A description of any additional material or information necessary to complete your Claim for benefits and why that material or information is necessary;

A description of the Plan’s Internal Appeal procedure and External Review process, including the time limits and how to begin the appeal process;

A statement of your right to bring civil action under ERISA §502(a) after receiving an Adverse Benefit Determination;

Information on any internal rule, guideline or protocol used in making an Adverse Benefit Determination on your Claim and that you are entitled to a copy of that material without charge;

Any information, explanation or documentation used if the Adverse Benefit Determination is based on the absence of medical necessity or the treatment was considered Experimental or Investigative or not medically appropriate, and will be furnished without charge;

The availability and contact information for the assistance of an ombudsman to assist with the Internal Appeal and External Review processes; **and**

With respect to Urgent Care Claims, a description of the expedited review process available for these types of Claims.

How to appeal an Adverse Benefit Determination through the Internal Appeals Procedures

If your Claim is denied in whole or in part, (an Adverse Benefit Determination) or if you disagree with the decision made on your Claim, you **or your Authorized Representative** may request a review by the Board through the Internal Appeals process. Your request for review must:

Be made in writing;

- State the reason(s) for disputing the denial (the Adverse Benefit Determination);
- Include any pertinent materials not already furnished to the Plan; **and**
- Be submitted within 180 days from the date you receive the Adverse Benefit Determination.

Authorized Representative

A claimant may designate a person to act as his authorized representative, such as a spouse or an adult child, to submit a request for review on behalf of the claimant. The claimant must sign and submit a written authorization form that has been approved by the Board. The Trust Fund Office may request additional information to verify that the designated person is authorized to act on the claimant's behalf.

A health care provider with knowledge of the claimant's medical condition may act as an Authorized Representative in connection with a request for a review of an Adverse Benefit Determination without the claimant having to designate the health care provider to act.

The Internal Appeals Procedures

You have the right to review documents relative to your Claim. A document, record or other information is "relevant" if it was relied upon by the Plan in making the decision on your Claim; it was submitted, considered, or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for providing consistent decision making; or it constitutes a statement of Plan policy regarding the denied treatment of service.

Upon request, you will be provided with the identification of the appropriate medical expert, consultant, or advisor, if any, that gave advice to the Plan on your Claim, without regard to whether the advice of those experts was relied upon in deciding your Claim.

A different person will review your Claim from the one who made the original decision. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including any additional documents and comments that may be submitted by you.

If your Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigative or experimental), a health care professional with the appropriate training and experience in a relevant field of medicine will be consulted.

When You Can Expect a Decision through the Internal Appeals Process

Pre-Service Claims: You can expect to receive a decision within **30 days** from receipt by the Trust Fund Office of your request for a review of your denied Claim.

Urgent Care Claims: You can expect to receive a decision within **72 hours** of receipt by the Trust Fund Office of your request for a review of your denied Claim.

Post-Service Claims: Usually, decisions involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt by the Trust Fund Office of your request for review. However, if your request for review is received by the Trust Fund Office within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request for review. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised, in writing, in advance if this extension will be necessary. Once the decision on your Claim has been reached, you will be notified as soon as possible, but no later than **5 days** after the decision has been made.

Content of the Appeal Decision Notice

The decision on your appeal will be provided to you in writing.

If the decision is an Adverse Benefit Determination, the notice must include:

- The identity of the Claim that was denied, including the date of service, the provider and the Claim amount;
- Information concerning the diagnosis code, treatment code and what those codes mean which is available upon written request and without charge;
- The specific reason for the Adverse Benefit Determination, including the denial code and the meaning of that code as well as the standards of the Plan used in making the determination;
- The specific Plan provision on which the Adverse Benefit Determination is based;
- A statement advising that you are entitled to reasonable access to and copies of all documents that apply to your Claim, upon written request and without charge;
- A statement of your right to bring civil action under ERISA §502(a) after an appeal of an Adverse Benefit Determination;
- An explanation of any External Review process, including any time limits and information on how to start the next level of review;

- A copy of any internal rule, guideline or protocol used in the determination of your appeal, upon written request and without charge;
- Information, explanation or documentation if the determination is based on medical necessity, the treatment was Experimental or Investigative or not medically appropriate. This information will be available upon written request and without charge; **and**
- A statement that you and your Plan may have other voluntary dispute resolution options such as mediation as well as disclosure of the availability and contact information of an ombudsman to assist you with the Internal and External Review processes. Information concerning these options are available from the U.S. Department of Labor.

External Review Process

For more information, see “Time Frames during the Federal External Review Process” in Appendix 1, page 107.

If you are still not satisfied with the decision made after participating in the Plan’s Internal Appeals process, you have the right to seek an External Review which is performed by an Independent Review Organization (IRO). This review is available for health care Claims whether they are Pre-Service, Urgent, Concurrent or Post-Service Claims **and** fit within the following parameters:

1. The denial involves a medical judgment, including, but not limited to, those based on the Plan’s rules concerning medical necessity, medical appropriateness, health care setting, level of care or a determination that the treatment is Experimental or Investigative. The IRO will determine if the denial involves a medical judgment; and/or
2. The denial is due to a Rescission of Coverage.

The External Review process does not apply to any other types of Adverse Benefit Determinations and only applies to health care Claims. In most cases, you can only request an External Review after you have exhausted the Plan’s Internal Appeals process. This means you must have received a final determination on an internal review before you can request an External Review.

Because the External Review process is only available for Claims involving medical judgment, there are only two types of Claims that will be considered. They are: 1) Standard (Non-Urgent) Claims; and (2) Expedited Urgent Claims.

1. External Review of Standard (Non-Urgent) Claims.

You must request an External Review in writing and within 4 months after receiving an Adverse Benefit Determination through the Internal Appeals process.

A. Preliminary Review of Standard Claims.

1. The Plan has **5 business days** to complete a preliminary review of your request for an External Review. The preliminary review will determine whether:

- (a) You were covered under the Plan at the time of the health care service or item was requested.
 - (b) The Adverse Benefit Determination does not involve eligibility requirements, including the failure to pay required premiums;
 - (c) You have exhausted the Plan's Internal Appeals process; and
 - (d) You have provided all of the requested information and forms to complete the External Review.
2. Within **1 business day** after completing the preliminary review, the Plan will notify you if you have met all of the requirements for an External Review. The notification will inform you:
- (a) If your request is complete and eligible for an External Review; **or**
 - (b) If your request is complete, but not eligible for an External Review and why it is not eligible for an External Review. The notification will also provide you with the contact information of the Employee Benefits Security Admistration (EBSA).
 - (c) If your request is incomplete, the notification will describe the information or material needed to complete your request for an External Review. You must perfect your request within the 4 month filing period or within 48 hours following receipt of the notification, whichever is later.
- B. Review of Standard Claims by an Independent Review Organization (IRO).
1. If your request is complete and eligible for an External Review, the Plan will assign your request to an IRO. Once the Claim is assigned to an IRO, the following procedure will apply:
- (a) The IRO will notify you in writing that it has received your request confirming your eligibility for an External Review and the IRO's acceptance of the request. You will also be given directions on how to submit additional information which should be submitted within **10 business days**.
 - (b) Within 5 business days of assigning your request for External Review to the IRO, the Plan will furnish the IRO with documents and information the Plan used in making the Adverse Benefit Determination.
 - (c) If you submit additional information to the IRO, the IRO must forward that information to the Plan within **1 business day** so that the Plan may use that information in reconsidering the initial Adverse Benefit Determination. In no event will this reconsideration by the Plan delay the External Review. If the Plan reverses the Adverse Benefit Determination, the Plan must notify the IRO within **1 business day** and the External Review process will terminate.

- (d) The IRO will review all of the information and documents that have been received in a timely manner. The IRO is not bound by any decision made by the Plan; however, the IRO will be bound by the terms of the Plan and cannot override the Plan Rules. As part of the External Review, the IRO may consider your medical records, recommendations from your treating health care provider, appropriate practice guidelines and other related medical information.
- (e) The IRO will provide you and the Plan with a written notice of its final External Review decision within **45 days** after receiving the request for External Review.
- (f) The IRO's decision notice will include:
 - 1) Information sufficient to identify the Claim, diagnosis code, treatment code, the meaning of these codes and the reason for the previous denial;
 - 2) The date the IRO received the request for External Review and the date of the decision;
 - 3) The evidence or documentation considered in reaching the decision, including specific Plan provisions and evidence based standards;
 - 4) A discussion of the reasons for the IRO's decision;
 - 5) A statement that the Plan must comply with the IRO's decision;
 - 6) A statement that a review by a court may be available, including the contact information for the Office of Health Care Consumer Assistance or ombudsman to assist you with your External Review.
 - 7) If the IRO decision reverses the Plan's Adverse Benefit Determination, upon receipt of this notice by the Plan, the Plan must immediately comply with the IRO's decision. However, the Plan still has the right to seek review by a court to change the IRO's decision; **or**
 - 8) If the IRO upholds the Plan's Adverse Benefit Determination, you may seek review of the result of the External Review under ERISA §502(a).

2. **External Review of Expedited Urgent Care Claims.**

A. You may request an Expedited External Review if:

- 1. You receive an adverse **initial** Claim Benefit Determination that involves a medical condition which requires a quicker response so as to not jeopardize your life or health, and you have filed a request for an expedited internal review; or

2. You receive an Adverse Benefit Determination on an Internal Appeal that involves a medical condition which requires a quicker response so as to not jeopardize your life or health; or you receive an Adverse Benefit Determination that concerns an admission or availability of care for which you received emergency services but have not been discharged from the facility.

B. Preliminary Review for an Expedited Claim.

The Plan will immediately take the following steps:

1. Upon receipt of the request for an External Review, the Plan will complete a Preliminary Review (see Review of Standard Claims on page 93);
2. After completing the Preliminary Review, the Plan will notify you by telephone as to whether or not your request met the Preliminary Review criteria; **and**
3. If the request does not meet the Preliminary Review criteria, you will be advised of what information is still needed.

C. Review of Expedited Claim by an **I**ndependent **R**evision **O**rganization (IRO).

The procedure for an External Review of an Expedited Claim by an IRO is the same as that of the IRO's review for Standard (Non-Urgent) Claims with one exception. An External Review for an Expedited Claim must be resolved within **72 hours or less**.

Once you receive the decision of the IRO regarding the External Review of your Expedited (Urgent) Claim, you have a right to seek review by a court under ERISA §502(a).

Limit on When You May Begin a Lawsuit (Civil Action)

You may not begin a lawsuit against the Fund to obtain benefits until after the following events have occurred, regardless of the type of Claim submitted:

- You requested an internal review of the denial of your Claim and the Board has reached and issued a final decision on your review; **or**
- You requested an External Review, but have not received either a notice within the specified time frames that a **final** decision has been reached **or** a notice that an extension will be necessary to reach a **final** decision.

Information Required Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996

Direct Payment or Kaiser Permanente Plan

Privacy of Your Health Information under HIPAA

This section describes how Health Information about you or your Dependents may be used and disclosed and how you or your Dependents can obtain access to Health Information maintained by the Cement Masons Health and Welfare Trust Fund for Northern California (“Health Plan”).

In General

You have certain rights under the HIPAA Privacy Rule with regard to your Health Information maintained by the Cement Masons’ “Health Plan”.

The HIPAA Privacy Rule establishes national standards to protect individuals’ medical records and other personal Health Information and applies to Health Plans, health care clearinghouses, and those health care providers that conduct certain electronic health care transactions. This Privacy Rule requires appropriate safeguards be put in place to protect the privacy of personal Health Information and sets limits and conditions on the uses and disclosures of that information without patient authorization. The Privacy Rule also gives patients certain rights regarding their Health Information, including the right to examine and obtain a copy of health records and to request corrections.

Privacy Notice

The HIPAA Privacy Rule requires Health Plans, as well as covered health care providers, develop and distribute a “notice” that provides a clear, user friendly explanation of individual’s rights with respect to their personal Health Information and the privacy practices of Health Plans and health care providers. In the case of the Health Plan, you will be provided with a Privacy Notice which will be included in the New Eligible Packet you receive from the Trust Fund Office once your eligibility under the Plan has been established. While you remain eligible under the Plan, you can expect to receive a Privacy Notice every three years. You can also read or download a copy of the Privacy Notice on the Funds’ website.

The Privacy Notice explains how the Cement Masons’ Health Plan, which is a member of an “Organized Health Care Arrangement”, uses and discloses your Health Information, and what rights you have with respect to that information. The terms “Plan”, “Plan Administration Team” and “Team Member” apply to the Health Plan in which you are a Participant.

If you have questions about the Privacy Notice, contact the Fund’s HIPAA Compliance Director, Northern California Cement Masons Funds Administration, Inc., at 1 888 245 5005 within California or 1 707 864 3300 for all other locations.

You can also learn more about HIPAA and your Privacy Rights by visiting the website for the Department of Health and Human Services/Health Information Privacy:

www.hhs.gov/ocr/privacy

Changes to the Privacy Notice

The Cement Masons' Health Plan reserves the right to change the content of the Privacy Notice but the Privacy Notice must always comply with the requirements of HIPAA.

Other Privacy Notices

Your health care providers are also required by HIPAA to provide you with a Privacy Notice. Those privacy notices differ from the Cement Masons' Health Plan notice because they discuss how your health care providers use your Health Information. The Cement Masons' Health Plan Privacy Notice applies only to the **Protected Health Information (PHI)** obtained and maintained by the Health Plan and describes your rights with respect to your Health Information maintained **by the Health Plan**, and how the Health Plan may use and disclose that Health Information.

Who Sees Your Health Information?

The Plan Administration Team includes all individuals who must see Health Information that can be linked to an individual's **Protected Health Information (PHI)** in order to operate the Health Plan. Members of the Team are employees of the Fund's Administrative Office which handles the day-to-day operation of the Cement Masons' Health Plan.

Other members of the Team include employees of outside organizations that assist with the operation of the Health Plan. In order to serve as Team Members, an individual must complete extensive training on privacy and security procedures. The law prohibits Team Members from using **Protected Health Information (PHI)** for improper purposes. Each Team Member understands that a violation of the Health Plan's privacy and security procedures may result in disciplinary action. Therefore, Team Members take the privacy of your Health Information seriously.

The Health Plan's Promise to You

Plan Administrative Team Members understand that your Health Information is private. The Board of Trustees for the Cement Masons Health and Welfare Trust Fund for Northern California is committed to using your Health Information only for the purposes of treatment, paying benefits, operating the Health Plan and, as expressly permitted or required by law.



How the Health Plan Uses and Discloses Your Health Information

Team Members can only use and disclose **Protected Health Information (PHI)** in ways that are expressly permitted by HIPAA. The sections entitled "Treatment", "Payment", and "Health Care Operations" describe how the Health Plan uses and discloses the Health Information obtained about you (your "Health Information"). Some of these uses and disclosures are routine, and are necessary to operate the Health Plan, and to provide assistance to health care providers who treat you. Others are not routine, but are required by law or necessary due to special circumstances. The Health Plan has developed procedures for all of these uses and disclosures. Because the Health Plan is a member of an "Organized Health Care Arrangement", the Health Plan may share your information with other

members of the “Organized Health Care Arrangement” for the purpose of “Treatment”, “Payment”, and “Health Care Operations”.

Treatment. Team Members may use or disclose your Health Information to facilitate medical Treatment or services by your health care providers such as doctors, nurses, technicians, medical students, other hospital personnel or pharmacies.

Payment. Team Members may use and disclose your Health Information in order to determine your eligibility for Health Plan benefits, to process Claims for Payment for your Treatment, or to determine whether any other plan or party might be responsible for Payment of your Treatment. For example, a Team Member might review a bill that contains Health Information about you in order to determine whether the Treatment is a Covered Expense under the Cement Masons’ Health Plan. Sometimes, a Team Member must obtain information from a health care provider or from your medical record to determine whether the Treatment provided is Medically Necessary, experimental or investigative. One Team Member may send information to another Team Member who is a medical specialist for the purpose of obtaining a medical opinion concerning the nature of the Claim. These are just a few examples of how Team Members may use and disclose your Health Information in order to make sure the benefits are properly paid.

Health Care Operations. Team Members may use and disclose your Health Information in order to conduct Health Plan operations. For example, Team Members may review your Health Information in order to:

1. Conduct quality assessment and improvement activities;
2. Perform underwriting, premium rating, and other activities relating to Health Plan coverage;
3. Submit Claims for stop-loss (or excess loss) coverage;
4. Conduct or arrange for medical review, legal services, audit services, and fraud and abuse detection programs;
5. Learn about ways to manage costs; **and**
6. Manage the business of the Health Plan to make sure it is administered properly and effectively.

Required By Law. Team Members will disclose your Health Information when required to do so by federal, state or local law. For example, a Team Member will disclose information about medical bills submitted by your health care provider in response to a court order in a litigation proceeding that claims the provider is involved in fraudulent bill practices.

To Prevent Serious Threats to Health or Safety. Team Members may use and disclose your Health Information in order to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure of this nature would only be made to a person who is able to help prevent the threat.

Special Situations

Organ and Tissue Donation. If you are an organ donor, Team Members may release your Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, in order to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces of the United States or any other country, Team Members may release your Health Information if the Health Plan is required to do so by the appropriate military command authorities.

Workers' Compensation. Team Members may release your Health Information if required to in order to comply with Workers' Compensation laws.

Health Oversight Activities. Team Members may disclose your Health Information to a Health Oversight Agency for activities authorized by law. These oversight activities may include audits, investigations, inspections and licensure. The activities are necessary for the government to monitor the health care system, government programs and compliance of civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, Team Members may disclose your Health Information in response to a court or administrative order. Team Members may also disclose your Health Information in response to a subpoena, discovery request, or other legal process by someone involved in the dispute, but only if efforts have been made to inform you of the request.

Law Enforcement. If requested to do so by a Law Enforcement Official, a Team Member may release your Health Information in response to a court order, subpoena, warrant, summons, or similar process.

Coroners, Medical Examiners and Funeral Directors. Team Members may release your Health Information to a coroner or medical examiner. This may be necessary, for example, to identify you if you die or to determine the cause of your death. Team Members may also release your Health Information to funeral directors as necessary to carry out their duties.

Your Rights Regarding Health Information the Plan Maintains about You

You have the following rights regarding the Health Information the Health Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy your Health Information used to make decisions about your Health Plan benefits. To inspect and copy the medical information used to make these decisions, you must complete a form entitled "**Request for Access to Protected Health Information (PHI)**" and submit this form to the Fund's HIPAA Compliance Director. If you request a copy of the information, you may be charged for the cost of copying, mailing and for any supplies associated with your request.

Right to Amend. If you believe the Health Plan has medical information about you that is incorrect or incomplete, you may ask that your Health Information be amended. You have the right to request an amendment for as long as the information is retained by or for the Health

Plan. To request an amendment, you must complete a form entitled **“Request for Amendment of Protected Health Information (PHI)”** and submit this form to the Fund’s HIPAA Compliance Director. Your request for an amendment may be denied if you do not complete this form. In addition, **your request may be denied if you ask the Fund to amend information that:**

1. Is not part of the medical information retained by or for the Health Plan;
2. Was not created by the Health Plan;
3. Is not part of the information which you would be permitted to inspect and copy; **or**
4. Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an “Accounting of Disclosures” where disclosures were made for any purpose other than Treatment, Payment, or Health Care Operations.

To request a list or Accounting of Disclosures, you must complete the form entitled **“Request for an Accounting of Disclosures of Protected Health Information (PHI)”** and submit this form to the Fund’s HIPAA Compliance Director. Your request must state the period of time for which you are requesting an Accounting of Disclosures. This period may not be longer than 6 years. Your request should indicate in what form you want to receive this information (for example: paper or electronic). The first request for information within a 12-month period will be free of charge. If you make any additional requests for information, the Trust Fund Office may charge you for the cost of providing this information. You will be notified of the cost in advance and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the Right to Request Restrictions or limitations on the Health Information the Health Plan uses or discloses about you for Treatment, Payment or Health Care Operations. You also have the right to request a limit on the Health Information **the Health Plan** discloses about you to someone who is involved in your care or the Payment for your care, such as a family member or friend. For example, you could request that the Health Plan not use or disclose Health Information to your spouse in connection with medical procedures.

To request that restrictions be placed on the disclosures of your Health Information, you must complete the form entitled **“Request for Restriction of Protected Health Information (PHI)”** and submit this form to the Fund’s HIPAA Compliance Director. You should understand that the HIPAA Compliance Director is not obligated to comply with your request.

Right to Request Confidential Communications. If you believe that the normal form of communication of Health Information is unacceptable, you have the right to request that the Health Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can request that the Health Plan only contact you at work or by mail.

To request confidential communications, you must complete the form entitled **“Request for Confidential Communications of Protected Health Information (PHI)”** and submit this form to the Fund’s HIPAA Compliance Director. You will not be asked the reason for your request and

the Administrative Office will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Cement Masons Health and Welfare Trust Fund for Northern California (Health Plan) or with the Secretary of the Department of Health and Human Services (**HHS**). To file a complaint with the Health Plan, write to the Fund's HIPAA Compliance Director.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or any law that applies to the Cement Masons Health Plan will be made only with your written authorization. If you provide the Health Plan with an authorization to use or disclose Health Information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Health Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You should understand that the Health Plan will be unable to recall any disclosures already made based upon your authorization. To request authorization for use or disclosure of your Protected Health Information (PHI), you must complete the form entitled "**Authorization for Use or Disclosure of Protected Health Information**" and submit this form to the Fund's HIPAA Compliance Director.

Where to Obtain HIPAA PHI Forms

You can call the Trust Fund Office and ask that the form(s) be mailed to you or you may print any of the HIPAA PHI forms from the Funds' website:

- "Request for Access to Protected Health Information (PHI)"
- "Request for Amendment of Protected Health Information (PHI)"
- "Request for an Accounting of Disclosures of Protected Health Information (PHI)"
- "Request for Restriction of Protected Health Information (PHI)"
- "Request for Confidential Communications of Protected Health Information (PHI)"
- "Authorization for Use or Disclosure of Protected Health Information (PHI)"

Where to File Complaints or Send Completed HIPAA PHI Forms

All complaints and completed HIPAA PHI Forms should be submitted to the Fund's HIPAA Compliance Director, Northern California Cement Masons Funds Administration, Inc., 220 Campus Lane, Fairfield, CA, 94534-1499.

Organizations through Which Benefits Are Administered or Provided

<p>Anthem Blue Cross of California 21555 Oxnard Street, M/S 10-H2 Woodland Hills, CA 91367 Provides claims management, Utilization Review, network services and case management for the Fund's self-funded Direct Payment Plan</p>	<p>Delta Dental of California 100 First Street San Francisco, CA 94105 Administers the Fund's self-funded dental plan</p>
<p>Kaiser Foundation Health Plan Northern California Region 1950 Franklin Street Oakland, CA 94612 Provides the prepaid insured HMO plan</p>	<p>DeltaCare USA 17871 Park Plaza Drive, Suite #200 Cerritos, CA 90703 Provides the fully insured Dental DHMO Plan</p>
<p>OptumRx 2300 Main Street Irvine, CA 92614 Pharmacy Benefit Manager for the Fund's self-funded Retail, Mail Order and Specialty Pharmacy benefits</p>	<p>UnitedHealthcare Dental 6220 Old Dobbin Lane Columbia, MD 21045 Provides the fully insured Dental DHMO Plan</p>
<p>Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 Administers the self-funded vision plan</p>	

HIPAA also requires that the Trust Fund Office inform you of the Department of Labor address in Washington, D.C. If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor:

EBSA
U.S. Department of Labor
200 Constitution Avenue N.W. | Washington, D.C. 20201

**Information Required by the
Employee Retirement Income and Security Act of 1974
(ERISA)**

Direct Payment and Kaiser Permanente Plan

1. The Plan is administered by a Joint Board of Trustees at the following address:

Board of Trustees
Cement Masons Health and Welfare Trust Fund for Northern California
220 Campus Lane | Fairfield, CA 94534-1499
888-245-5005 within California | 707-864-3300 all other locations

2. The Trust Fund Office will provide any Eligible Individual, upon written request, information as to whether a particular employer is contributing to the Fund with respect to the work of Participants in the Fund and if the employer is a contributor, and the employers address.
3. The Employer Identification Number (EIN) issued to the Board of Trustees by the Internal Revenue Service is 94-1291152.
4. The Plan Number is 501.
5. This is a Welfare Plan which provides hospital, medical, drug, dental, vision care and death and accidental death and dismemberment benefits.
6. The person designated as agent for the service of legal process is the Fund Administrator:

Mr. Byron C. Loney, Secretary
Cement Masons Health and Welfare Trust Fund for Northern California
220 Campus Lane | Fairfield, CA 94534-1499

7. The service of legal process may also be made upon a Plan Trustee—their names and business addresses are:

Employee Trustees	Employer Trustees
Mr. Hector Cortez, Chairman Cement Masons Local #400 810 West Stadium Lane Sacramento, CA 95834	Mr. Brian Gardner, Co-Chairman Kiewit Infrastructure West Company 4650 Business Center Drive Fairfield, CA 94534
Mr. Ben Espinoza Cement Masons Local #400, Area 631 404 Nebraska Street Vallejo, CA 94590	Mr. Shawn Barnes Harbison-Mahony-Higgins Builders, Inc. Db a Concrete Services 8220 Siena Avenue Sacramento, CA 95828
Mr. Keith Shanks Cement Masons Local #300, Area 594 8400 Enterprise Way, Suite #111 Oakland, CA 94621	Mr. Robert Dumesnil Dolan Concrete Construction 3045 Alfred Street Santa Clara, CA 95054
Mr. Greg Levy Cement Masons Local #300, Area 594 8400 Enterprise Way, Suite #111 Oakland, CA 94621	Mr. Mark Reynosa Associated General Contractors of California, Inc. 1906 W. Garvey Avenue, Suite #100 West Covina, CA 91790

8. This program is maintained pursuant to various collective bargaining agreements. Copies of the collective bargaining agreements are available for inspection at the Trust Fund Office during regular business hours and, upon written request, will be furnished by mail. A copy of any collective bargaining agreement which provides for contributions to this Fund will also be available for inspection within 10 calendar days after written request at any of the Local Union offices or at the office of any Contributing Employer to which at least 50 Plan Participants report each day.
9. The requirements for eligibility for benefits are set forth on page 12 of this SPD and in Article II of the Plan Rules and Regulations, a copy of which is available online at www.NorCalCementMasons.org.
10. The circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of benefits are set forth on page 12 of this SPD and in Article II of the Plan Rules and Regulations.
11. All contributions to the Fund are made by Individual Employers in accordance with collective bargaining agreements in force with the District Council of Plasterers and Cement Masons of California, affiliated Local Union or other entity related to the Fund, with respect to certain of their employees pursuant to Board regulations.
12. Benefits are provided from a trust fund and insurance contracts through Kaiser Foundation Health Plan Northern California Region; UnitedHealthcare Dental and DeltaCare USA.
13. The end of the year for the purpose of maintaining the Fund’s fiscal records is August 31st (the ERISA Plan Year).
14. The procedure for filing claims is set forth on page 84.

Statement of Rights

Under the Employee Retirement Income Security Act of 1974

(ERISA)

Direct Payment and Kaiser Permanente Plan

As a Participant in the Cement Masons Health and Welfare Trust Fund for Northern California, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA provides that all Plan Participants are entitled to the following rights:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents governing the Plan. These documents include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor (DOL) and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration). You may also locate a copy of the Form 5500 series on the DOL/EBSA website: www.dol.gov/ebsa/.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The administrator may make a reasonable charge for the copies. You may also locate the Plan's SPD on the Fund's website and the Form 5500 series can be located on the DOL/EBSA website www.dol.gov/ebsa/.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or Dependent children if there is a loss of coverage under the Plan as a result of a Qualifying Event (see page 27). You or your Dependents may have to pay for such coverage. Review this Summary Plan Description (SPD) and the documents governing the Plan on the rules of your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a welfare benefit is denied, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a Claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court, once you have exhausted the appeals process described in “Claims and Appeals Procedures” in this SPD. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor (DOL), or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor (DOL), listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at 1 866 444 EBSA (3272) or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration (EBSA)
U.S. Department of Labor
200 Constitution Avenue N.W. | Washington, D.C. 20210

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA. For single copies of publications, contact the EBSA brochure request line at 1 800 998 7542 or contact the EBSA field office nearest you. You may also find answers to your plan questions and a list of EBSA field offices at the website of EBSA at www.dol.gov/ebsa.

Appendix 1 – Overview of the Time Frames During the Federal External Review Process (Direct Payment Plan)

Step #	Steps in the External Review Process	Time Frame for Standard (non-urgent) Claims	Time Frame for Expedited Urgent Care Claims
Step 1	Claimant requests an External Review (generally after the Internal Claims Appeals procedures have been exhausted)	Within 4 months after receipt of an Adverse Benefit Determination (benefits denial notice)	After receipt of an Adverse Benefit Determination (benefits denial notice)
Step 2	The Plan performs a preliminary review	Within 5 business days following the Plan's receipt of the request for an External Review	Immediately
	<ul style="list-style-type: none"> Plan sends notice to claimant regarding the results of the preliminary review 	Within 1 business day after the Plan's completion of the preliminary review	Immediately
	<ul style="list-style-type: none"> When appropriate, claimant's time frame for perfecting an incomplete External Review request 	The remainder of the 4 month filing period, or if later, 48 hours following receipt of the notice that the External review is incomplete	Immediately
Step 3	Plan assigns case to the Independent Review Organization (IRO)	In a timely manner	Expediently
Step 4	Notice from the IRO to the claimant advising that the case has been accepted by the IRO for External Review along with the time frames for submission of any additional information	In a timely manner	Expediently
Step 5	Time period for the Plan to provide the IRO documents and information that the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expediently
Step 6	Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information (the IRO may accept information after 10 business days)	Expediently
Step 7	The IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expediently
Step 8	If, on account of the new information submitted by the claimant, the Plan reverses its denial and provides coverage, a Notice is provided to the claimant and the IRO	Within 1 business day of the Plan's decision	Expediently
Step 9	The External Review decision by the IRO to the claimant	Within 45 calendar days of the IRO's receipt of the request for an External Review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for an expedited External Review (if notice is not in writing within 48 hours of the date of providing such non-written notice, the IRO must provide written notice to the claimant and the Plan)
Step 10	Upon Notice from the IRO that it has reversed the Plan's Adverse Benefit Determination	Plan must immediately provide coverage or payment for the Claim	Plan must immediately provide coverage or payment of the Claim