

Cement Masons

Benefit Bulletin

Assisting you in understanding your benefits

Mental Health Benefit

Active and Retired Participants under the Direct Payment Plan



At one time or another we experience life events, situations or issues that we are not emotionally prepared to handle. Active and Retired participants have a mental health benefit to provide guidance when emotionally charged issues arise.

The mental health benefit covers treatment of mental or psychiatric disorders including, but not limited to, psychotherapy and psychological testing provided by a psychiatrist, psychologist, or licensed clinical social worker.

To use this benefit, speak with your primary care physician about a referral to a specialist.

Outpatient

Participating Providers

50% of negotiated rate,
limit of 40 visits per Plan Year.

Non Participating Providers

50% of ¹UC&R,
limit of 20 visits per Plan Year.

Inpatient

Participating Providers

100% of negotiated rate,

Non Participating Providers

60% of first \$15,000 of covered charges,
100% thereafter.

¹ UC&R means Usual, Customary and Reasonable (Cement Mason Health and Welfare Plan Booklet: Article I., Section 39., page 73)

Active Plan Chemical Dependency Treatment Benefit

Active Plan Participants Only

If you or one of your dependents enters an inpatient alcohol or drug rehabilitation program, the Fund will pay:

- 50% of covered charges.

Plan restrictions are as follows:

- Maximum of 15 days of confinement in a 12 consecutive month period.
- Maximum of 30 days of inpatient treatment Benefits are provided during the lifetime of the eligible individual.
- Benefits do not cover confinement for the convenience of the individual.
- No outpatient treatment available.



Kaiser members must use **Kaiser's** Chemical Dependency Treatment Program.

Health Plan Options

The Direct Payment Plan utilizes Anthem Blue Cross' Prudent Buyer providers in the PPO network. You may use any doctor, however to reduce out of pocket costs use a provider in the PPO network.

Kaiser Permanente utilizes a network of providers who participate in the HMO system. You may only use a provider that is part of Kaiser's staff at Kaiser locations.

You can change Medical Plans a maximum of two times each year.

Plan Terms

Co-Insurance: The percentage you pay as your share of medical costs in addition to copayment and Plan Year Deductible.

When a participant uses the Emergency Room, he would pay the Plan Year Deductible, copayment and co-insurance. The Fund pays the balance of the invoice *after* the Plan Year Deductible and copayment has been met.

EXAMPLE

EMERGENCY VISIT TOTAL DUE \$1,698.00

ACTIVE PLAN

Item	In Network PPO	Out of Network PPO
Plan Year Deductible <i>\$150/individual</i>	\$ 0.00	\$ 150.00
Copayment	\$100.00	\$ 100.00
Co-Insurance	0% <i>of negotiated rate</i>	40% <i>of covered charges</i>
Amount	\$ 0.00	\$ 579.20
Total share in costs	\$ 100.00	\$ 829.20
Fund Pays	\$1,598.00	\$ 868.80

RETIRED PLAN

Item	In Network PPO	Out of Network PPO
Plan Year Deductible <i>\$150/individual</i>	\$ 150.00	\$ 150.00
Copayment	\$ 100.00	\$ 100.00
Co-Insurance	20% <i>of negotiated rate</i>	40% <i>of covered charges</i>
Amount	\$ 289.60	\$ 579.20
Total share in costs	\$ 539.60	\$ 829.20
Fund Pays	\$1,158.40	\$ 858.80

IMPORTANT

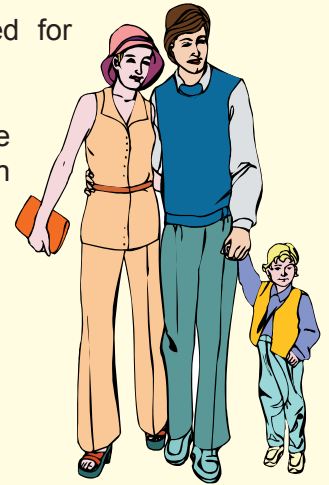
The following items have been included with this issue of the *Benefit Bulletin*:

- VSP Grievance System Notice

Summary of Accumulated Credited Service

Credited Service is used for vesting purposes.

Benefit Units earned are used to calculate a pension benefit amount.



Did you know that you can request a copy of your Summary of Accumulated Credited Service and Benefit Units?

To review the number of Years of Credited Service and Benefit Units you have earned, send a written request to the Pension Department for a copy of your Summary.

We encourage you to review your Summary at least once a year.

A Complete Enrollment Form Keeps Your Records Current

Save yourself a headache or worry about your benefits. Complete an Enrollment Form for all life changes.



Marriage, Beneficiary, Divorce, Birth, Adoption, Legal Guardianship, or Custody of a Stepchild



Attach a COPY of supporting documents for all updates you want to implement as stated on the Enrollment Form. This will prevent the frustration of a denied medical claim or benefits paid to an incorrect beneficiary.

BENEFIT CONTACT INFORMATION



Delta Dental Premier
800-765-6003
www.deltadentalca.org

DeltaCare USA (HMO)
800-422-4234
www.deltadentalca.org

Pacific Union Dental
800-999-3367
www.pacificuniondental.com

Rx Solutions
800-562-6223
www.rxsolutions.com

Vision Service Plan
800-877-7195
www.vsp.com

Kaiser Permanente Senior Advantage
800-464-4000
www.kaiserpermanente.org



Grievance System

As required by California regulations, Vision Service Plan (VSP) is informing its members of the following information:

If a VSP member has a complaint/grievance regarding VSP and/or a VSP network doctor, you may immediately call VSP's Member Service Department at 800-877-7195 Monday through Friday, 6:00 a.m. to 7:00 p.m. (PST), or sign on to vsp.com and complete the online Member Grievance Form. You may also submit a grievance in writing to VSP at 333 Quality Drive, Rancho Cordova, California 95670.

Upon receipt of your verbal or written grievance, VSP will respond to you in writing acknowledging receipt and/or disposition of the grievance within five (5) business days. VSP will resolve your grievance within thirty (30) days from the date of receipt and keep your grievance and the response on file for seven (7) years.

Notice from the Department of Managed Health Care:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 877-7195** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site <http://www.hmoHELP.ca.gov> has complaint forms, IMR application forms and instructions online. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to Covered Persons, and the failure to use these procedures does not preclude Covered Person's use of any other remedy provided by law.