



Cement Masons Benefit Bulletin

Assisting you in understanding your benefits

Medical Plan Identification Cards and Claims Mailing Address

In April 2009, Participants enrolled in the Direct Payment Plan received their new Medical Plan Identification Card. The new card provides participant identification numbers and a new mailing address for medical claims to be sent for processing. Some Plan Participants and providers, however, continue to send medical claims to the Trust Fund Office at 220 Campus Lane, Fairfield, CA 94534. Sending your medical claims to the Trust Fund Office, will cause a delay in the processing and payment of those claims.

It is important that you tell your doctor or any other medical provider to update their records with the new mailing address, the new group number and member identification number that begins with OCWCM.

Beginning October 26, 2009, medical claims received at the Trust Fund Office will be returned to the sender.



Anthem Blue Cross Medical Claims Mailing Address

For services received in California, mail medical claims to:

Anthem Blue Cross of California
PO Box 60007
Los Angeles, California 90060-0007

For services received outside California, your provider should mail medical claims to the Blue Card Plan in the state where services were received.



CEMENT MASON HEALTH AND
WELFARE TRUST FUND FOR
NORTHERN CALIFORNIA

JOHN MASON
Identification Number
OCWCM0001234

Group No: 170257M001
Plan Code: 040
Coverage(s): Medical

PRUDENT BUYER PLAN®



Your medical identification card should have a suitcase logo indicating that you belong to the Blue Card Plan and where to submit your claim.

Disability Pensions

If you are an applicant for a Disability Pension or you are a Pensioner in receipt of a Disability Pension from the Plan and you are approved for a Disability Benefit from the Social Security Administration, a copy of the Social Security Notice of Award or the Notice of Favorable Decision, must be received at the Trust Fund Office no later than 12 months from the date on the Notice.

If the Social Security Notice is not received at the Trust Fund Office within 12 months from the date on the Notice, the effective date (Annuity Starting Date) of your Disability Pension, if you are approved, would be the first of the month following the month your Pension Application is received at the Trust Fund Office.

Always refer to the Summary Plan Description and the Rules and Regulations of the Pension Plan to see how the rules for Disability Pensions apply to your individual situation.



IMPORTANT

The following item has been included with this issue of the *Benefit Bulletin*



Vision Service Plan's:
Grievance System Notice

Reimbursement Rate Exception

Covered Expense by a Non-Participating Provider is payable at 60% of Usual Customary and Reasonable (UC&R) charges after your Plan Year Deductible and copayment are satisfied, with the exception of:



Emergency Room Physicians: For covered and Medically Necessary services by a Non-Participating Provider at a participating Hospital, the Plan will pay 90% (Active Plan) and 80% (Retired Plan) of UC&R charges. This exception does not apply to other Non-Participating professional services such as surgery, anesthesia, and daily hospital visits.

Ambulance Services: For Medically Necessary ambulance transportation by a Non-Participating Provider ambulance service if requested by a Hospital or by paramedic personnel, the Plan will pay 90% (Active Plan) and 80% (Retired Plan) of UC&R charges.

Kaiser Plan Participants Non-Medicare Retirees

As stated in your October 30, 2009 Notice, Effective January 1, 2010, Non-Medicare Retirees will have a higher share of costs.

Cost sharing includes:

- Copayments,
- Calendar Year Deductible, and
- Coinsurance on many covered services.

If you wish to change your Plan to the Direct Payment Plan, call the Trust Fund Office for enrollment materials. If you wish to stay with Kaiser, do nothing.

Emergency Room Services

When you use the Emergency Room at the hospital, in addition to your Plan Year Deductible and co-insurance, you will have an additional copayment*.



Additional Copayment

Participating Hospitals: \$100

Non Participating Hospitals: \$100

Emergency Services are Medically Necessary treatments required as the result of a life-threatening condition. Some examples of life-threatening conditions requiring Emergency Service include, but are not limited to, heart attack, strokes, poisonings and appendicitis.

Using the Emergency Room to treat non-emergency conditions will increase your out-of-pocket share of costs. Use an Urgent Care Center that is part of the Anthem Blue Cross Prudent Buyer Network to save money on your share of out-of-pocket costs.

*Under some circumstances, the copayment is waived.

When Medical Claims Must Be Filed

Your provider should submit your medical claim within 90 days following the date charges were incurred (date of service). Failure to submit medical claims to Anthem Blue Cross within that time period will not invalidate or reduce your claim if it can be demonstrated that it was not reasonably possible to submit the medical claim within 90 days. In that case, your medical claim **must** be submitted as soon as it is reasonably possible, but under no circumstances, later than one year from the date charges were incurred (date of service).



HEALTH BENEFIT PROGRAMS

Delta Dental Premier
800-765-6003
deltadentalca.org

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

Pacific Union Dental
800-999-3367
pacificuniondental.com

Rx Solutions
800-562-6223
rxsolutions.com

Vision Service Plan
800-877-7195
vsp.com

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

DISCLAIMER

The Benefit Bulletin's purpose is to provide you and your family with information about the various benefits available and how to effectively use those benefits. There are exclusions and limitations in all Plans and you should carefully read those Plan Rules and Regulations. Health and Welfare Plan rules should be reviewed before seeking medical attention. Your rights as a Plan Participant or Beneficiary can only be determined by consulting the Rules and Regulations of the Plans.



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.