

## Trustees Lower Certain Prescription Drug Co-payments

As you know, this last September, the Board of Trustees made several changes to the health and welfare plan, necessary to control the rising cost of health care. Among the changes were increases in co-payments for prescription drugs. Though beneficial and, in many cases, life saving, pharmaceuticals is one of the reasons health care costs have risen so dramatically over the last few years.

As a means of cost sharing, co-payments were increased at the retail level from \$3 to \$10/prescription for generic drugs and from \$3 to \$20/prescription for brand name drugs. The days' supply was reduced from 60 to 30. At the mail order level, co-payments were added--\$20/prescription for generic drugs and \$40/prescription for brand name drugs. The days' supply was increased from 60 to 90.

After the program had been in place for a few weeks, the Trustees became aware that special consideration should be given when no generic equivalent is available. The Trustees conferred with the Fund's Consultant and Pharmacy Benefit Manager and concluded that the co-payment for a brand name drug where no generic equivalent is available, could be lowered from \$20/prescription to \$10/prescription for retail and, from \$40/prescription to \$20/prescription for mail order. This adjustment in the co-payment

became effective on October 1, 2003. A notice of this adjustment was mailed on October 3, 2003.

This applies only if no generic equivalent is available. If a generic equivalent is available and you or your physician requests a brand name, you will be responsible for payment of the co-payment *plus* the difference in cost between the generic and brand name drug. In many cases, this difference in cost can be substantial. As an example, Robaxin (a muscle relaxant) is the name brand for the generic methocarbamol. Robaxin costs \$97.00 for 180 tablets; the generic equivalent costs \$20 for 180 tablets. If you were to choose the name brand, Robaxin, you would pay a \$20.00 co-payment, plus the difference in cost between the generic and brand (\$97.00 - \$20.00 = \$77.00). In this example, your out-of-pocket cost would be \$97.00 for the name brand compared to \$20.00 for the generic.

Of course, the choice between brand name and generic is yours. Just be aware that if a generic is available and your preference is the brand name, you will pay more out-of-pocket costs. Generics are more cost effective for both you and the health plan. However, effective October 1, 2003, if there is no generic equivalent, you will only be responsible for a co-payment of \$10/prescription at the retail level or \$20/prescription through mail order.



## Kaiser Prescription Refills

When you have a hectic schedule, the things you need to do can slip away from you. But Kaiser Permanente can save you a trip to the pharmacy when you need to refill a prescription. You can order refills anytime you want by visiting [www.kponline.org](http://www.kponline.org) or calling the phone number highlighted on your prescription label. Prescriptions can be mailed or picked up. (Mail service is available for any medicine except those containing narcotics or certain liquids that may break, leak, or be affected by temperature changes.)

It's so easy. To refill prescriptions online or by phone, you need your Kaiser Permanente medical record number, the prescription number for each medication, and credit card number with expiration date. Orders are shipped free and should arrive within 5 to 7 business days.

**There are no notices inserted in this issue of the *Cement Mixer*.**





## California Smokers' Helpline

The California Smokers' Helpline is a telephone program that can help you quit smoking. The services are funded by the California Department of Health and provided at no cost to you.

When you call, you are offered a choice of services: self-help materials, a referral list of other programs, and one-on-one counseling over the phone.

Studies find that people who receive counseling, such as that offered through the Helpline, are more likely to succeed at quitting than those who try to go it alone.

Some of the free services provided by the Helpline include:

- Booklet with information on quitting smoking and staying tobacco-free.
- Referral list of groups or classes that meet in your area.
- Telephone counseling--you can talk to someone about quitting. You and your counselor will work together to develop a plan for you to quit smoking.
- Specialized assistance for teens, pregnant women, and those using chewing tobacco.

Anyone in California can call the Helpline whether you are currently smoking, have already quit, or want information for a friend or relative. **In English call 1-800-NO BUTTS, Monday-Friday, 9 AM to 9 PM. En Español--1-800-45-NO-FUME, Saturday, 9 AM to 1 PM.**

## Know your benefits... All Hospital Admissions Require Utilization Review



If you or a dependent is scheduled to be admitted to a hospital on an elective, non-emergency basis, you must be sure your physician arranges Utilization Review (UR) through Blue Cross, the Fund's Professional Review Organization (PRO). This review must be done *before* you enter the hospital.

**How does UR work?** The PRO reviews your case, taking into consideration the type of surgery you will be having and any special circumstances that may affect your inpatient stay. This process is called "Pre-Admission Review" and must be performed *prior* to your confinement for an elective, non-emergency stay. Based on this review, the PRO pre-authorizes a number of days for your inpatient stay.

Next, while you are in the hospital, the PRO follows up with another review called "Concurrent Review." In most cases, the PRO does not change the number of days it pre-authorized when it performed Pre-Admission Review. However, there may be instances in which the PRO, in consultation with your physician, changes the number of days originally authorized for your confinement. For example, the PRO may determine that your inpatient stay should be longer or, in some cases, shorter than originally authorized. The PRO will advise you of any change in the number of days, in time for you to make other arrangements, if necessary. If you are admitted to the hospital on an emergency basis, you only need to obtain Concurrent Review, as Pre-Admission Review would not be possible.


Because your Managed Health Care Plan uses Blue Cross' *Prudent Buyer Plan*

network, you most likely will be admitted to a participating hospital. When admitted to a participating hospital, the *Prudent Buyer Plan* arranges Utilization Review. However, always be sure your physician has arranged UR. If you are admitted to a non-participating hospital, your physician must arrange UR by calling Blue Cross at (800) 274-7767. If you are admitted to a non-participating hospital on an emergency basis, you or someone caring for your affairs should notify Blue Cross at (800) 274-7767 within 24 hours of your hospitalization. Blue Cross will then arrange Concurrent Review.

If you do not obtain Pre-Admission Review on an elective, non-emergency inpatient stay, you will be responsible for 20% of the first \$10,000--that is in addition to a 10% co-insurance if it is a participating hospital, or 30% if it is a non-

participating hospital. In other words, your out-of-pocket costs could be 30% or as much as 50% of the first \$10,000 for not complying with the UR provision.

A "Retrospective Review" may be performed if you failed to obtain Pre-Admission and Concurrent Reviews. A Retrospective Review is done *after* you have left the hospital. If the PRO determines that your inpatient stay was not medically necessary, no benefits will be paid. If, however, it determines your stay was medically necessary, you are still responsible for 20% of the first \$10,000 of benefits payable.

The important point is to inform your physician, or hospital, that your health plan requires Utilization Review (UR) on all hospital admissions. 

**Always inform your physician or hospital that your health plan requires Utilization Review (UR) on ALL HOSPITAL ADMISSIONS.**

## Filling out forms...

# Authorization For Use or Disclosure of Protected Health Information (PHI)


On April 14, 2003, the Health and Welfare Trust Fund implemented privacy rules mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These rules are to protect personal health information from improper uses and disclosures. In compliance with HIPAA, on April 4, 2003, the Trust Fund distributed to each Plan Participant an Information Privacy Notice, which describes how medical information may be used and disclosed and how you can obtain access to that information.

HIPAA provisions permit the Trust Fund to use Protected Health Information (PHI) for purposes of treatment, paying benefits, and operating the Plan. What is PHI? PHI is individually identifiable health information. That is, health information that identifies the Plan Participant, either by name or by any other means that could disclose the identity of the person. The Trust Fund only uses PHI for Plan administrative purposes and is committed to using health information as permitted by HIPAA.

You may wonder if any restrictions in this law affect you. What changed on April 14, 2003? Let's say you have always relied on your Local Union to contact the Fund Office to inquire of your claim status, eligibility or other information. As of April 14, 2003, the Trust Fund could no longer share this information, which is considered PHI, with anyone or any entity, other than as permitted by HIPAA. Someone (other than you) calling the Fund Office to ask the status of your claim is not allowed under HIPAA. The Fund Office cannot

share Protected Health Information with anyone other than you, in this example.

This can be an inconvenience for those who work and do not have time to contact the Fund Office or access to a telephone. Is there any way around this? The answer is "yes," however, you must provide written authorization to the Trust Fund, naming the individual you authorize to receive your PHI. To do so, you would complete a form entitled "Authorization for Use or Disclosure of Protected Health Information (PHI)." You may obtain this form by calling the Fund Office and requesting it, or you may download the form from the Fund's Web site at [www.norcalcementmasons.org](http://www.norcalcementmasons.org). Complete Sections A and B and submit the form to **HIPAA Compliance Director, Northern California Cement Masons Funds Administration, Inc., 220 Campus Lane, Fairfield, CA 94534**. You may designate a specific time frame (a start and an expiration date) in which you authorize someone to have your PHI. If you do not assign an expiration date, the Fund Office will continue to provide your PHI until you revoke the authorization. This can be done by completing and mailing a form entitled "Revocation of Authorization for Disclosure of Protected Health Information (PHI)." This form may be obtained by calling the Fund Office. It is not available on the Web site.

There are other forms required by the HIPAA law that deal with PHI; this article describes only two of these forms. For more information on privacy and Protected Health Information, refer to the Information Privacy Notice mailed to you in early April 2003. 

## Questions & Answers

**Q.** My wife has medical coverage with an HMO through her employer. Her HMO requires her to obtain medical care through her Plan's primary care physician, but she prefers my physician. Will Cement Masons pay for medical care she receives outside her HMO?

**A.** Since your wife has medical coverage through her employer, the Cement Masons Health and Welfare Plan pays **after** her Plan pays. It does not matter whether her coverage is through an indemnity plan, a PPO, or an HMO. The coverage available to her under Cement Masons is secondary. Her primary coverage is through her HMO.

If your wife chooses to see a physician outside her HMO, the Cement Masons Plan will compute an amount equal to what the other Plan would have paid. Any remaining balance, after applying what the other Plan would have paid, will be paid by Cement Masons, up to the total fees charged. However, if the other Plan denies reimbursement because your wife did not use her Plan's network, the Cement Masons Plan will not pay any benefits for expenses incurred.

This same policy applies whether or not your wife enrolls in medical coverage available through her employer. Cement Masons would compute an amount equal to what your wife's Plan would have paid and then will pay any remaining balance. If your wife's Plan would have denied those charges, Cement Masons will not pay any benefits for expenses she incurs.

Refer to Article VIII, Section 3.b. (page 69) of the Plan Rules and Regulations regarding coordination of benefits rules.

# CALENDAR

On or About This Date	We Will Mail	You Should
September 23, 2003 <i>(Mailed)</i>	Statement of Account for Work Period of February 1, 2003 - July 31, 2003	Verify hours and report any discrepancies to your Local Union. Retain statement for your records.
November 30, 2003	Vacation-Holiday Benefit Checks	Interested in having future vacation benefit checks deposited electronically? Contact the Vacation Department at the Fund Office.



## Contacting The Fund Office



Cement Masons Trust Funds  
220 Campus Lane  
Fairfield, CA 94534-1499

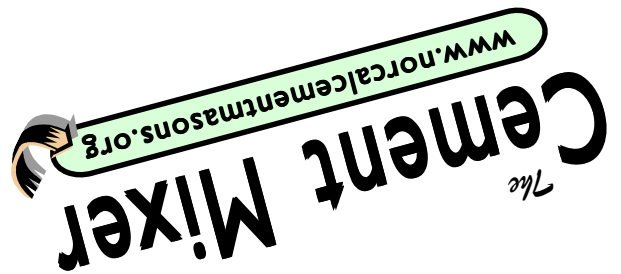
(707) 864 - 3300  
or Toll Free  
(888) 245 - 5005



Internet Web site:  
[www.norcalcementmasons.org](http://www.norcalcementmasons.org)



The *Cement Mixer* is published by the Northern California Cement Masons Funds Administration, Inc. and is intended to provide general information about the plans. It is not intended as a substitute for official Plan documents. Your rights as a Plan Participant or Beneficiary can only be determined by consulting the actual text of the Plan Booklet.



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