

Cement Masons Health and Welfare Trust Fund for Northern California
220 Campus Lane
Fairfield, CA 94534-1499
1 (707) 864-3300 or 1 (888) 245-5005
www.norcalcementmasons.org

IMPORTANT ANNOUNCEMENT

Please provide a copy of this Announcement to your Spouse and eligible adult children enrolled in the Plan

Your Benefits under the Affordable Care Act
INSERT WITH THE SUMMER, 2011 CEMENT MIXER

Date: July 15, 2011

To: All Eligible Active and Retired Plan Employees **including** eligible Dependents
➤ Direct Payment Plan and Kaiser Permanente Plan Members

Under the Affordable Care Act, (the Act), signed in to law on March 23, 2010, all Health Plans, except “*Retiree Only*” Plans and “*Limited Scope*” Dental and/or Vision Plans, are required to make certain benefit changes on the first day of the Plan Year following September 23, 2010. For the Cement Masons **Direct Payment Plan**, that date is **September 1, 2011**. The Dental and Vision Plans are “*limited scope*”, therefore, no changes to those plans are required.

The Cement Masons **Retired** Health and Welfare Plan is not a “Retiree Only” plan. The changes required by the Act **will apply** to the Retired Plan.

Under the Act, plans are referred to as “grandfathered” or “non-grandfathered”. While these terms will be explained at the end of this Announcement, what you need to know is that the **Direct Payment Plan** is no longer “grandfathered” as of **September 1, 2011** because of the benefit changes on January 1, 2011. The Kaiser Permanente Plan, however, remains “grandfathered” until June, 2013. Even though the Kaiser Permanente Plan remains grandfathered, the Board decided to make changes to the Kaiser Permanente Plan on **September 1, 2011** which are similar to those changes being made to the Direct Payment Plan.

The changes being made under the Act, are outlined below. **Read this information carefully because it can affect your benefits.**

Coverage for Dependent Children to Age 26 Direct Payment Plan and Kaiser Permanente Plan

If you have a child who lost coverage or who was denied coverage due to age or dependency restrictions, you now have the chance to enroll that child for coverage beginning **September 1, 2011**.

There is a special **One Time Open Enrollment Period** during which you can enroll an eligible child based upon the new rules in the Act.

Before September 1, 2011, dependent children were covered to the age of 19 or 23 if they were unmarried, a full-time student, and financially dependent upon the Cement Mason. Under the Act, the Cement Masons Plan is now required to allow **eligible** adult children to be covered **to their 26th birthday** so long as the Cement Mason remains eligible under the Plan.

Eligible children include natural or adopted children, stepchildren, foster children, and handicapped children. Coverage is available regardless of your child's marital status, student status, financial dependency upon you, whether or not they live in your home, or whether the child has another employer sponsored health plan.

Action Required:

If you have an **eligible** child who lost coverage **prior to September 1, 2011**, or who was denied coverage due to previous age or dependency restrictions, complete the Special Enrollment Form included with this Announcement and return it to the Trust Fund Office **by August 31, 2011**. For children who are in an eligible status on September 1, 2011, coverage will continue **to their 26th birthday**; no action is required by you. Coverage for your child is entirely dependent on **your continued eligibility**. If you lose eligibility, dependent coverage will also be lost.

If you are a Retiree, however, there may be an additional premium cost to add a dependent child. Call the Trust Fund Office for further information.

Coverage is being extended to **your** eligible child or children only. **It does not extend to their children (unless placed in your home under foster care or legally adopted by you) nor does it extend to their Spouse.**

KAISER PERMANENTE PLAN MEMBERS READ FURTHER IN THE ANNOUNCEMENT FOR INFORMATION ABOUT YOUR PLAN.

Comprehensive Medical Expense Benefit Lifetime Maximum – Direct Payment Plan Only

The current Lifetime Maximum under the "Comprehensive Medical Expense Benefit" is \$2,000,000 for the Active Cement Mason and \$400,000 for the Retired Cement Mason. Effective **September 1, 2011**, the Lifetime Maximum is removed for claims incurred on and after **September 1, 2011**. If there are eligible Plan Participants who *have met* or *will meet* the maximum benefit level, they will automatically be reinstated for Comprehensive Medical Expense Benefits for claims incurred **on and after September 1, 2011**. Medical Expenses incurred **before September 1, 2011** that were not payable due to exceeding the Plan's Lifetime Maximum will **not** be reimbursed by the Plan

Preventive Services - Direct Payment Plan

The Plan will pay 100% (no deductible, copayment, or coinsurance) of the PPO negotiated rate for **certain** covered Preventive care services **but only if you receive them from a Preferred Provider (PPO)**. The list of covered Preventive care services is extensive. You should visit the following web site to see the list of the no-cost Preventive care services covered under the Act:

<http://www.healthcare.gov/law/about/provisions/services/lists.html>

Routine Physical Examination Benefits – Direct Payment Plan

If you or your eligible dependents receive Routine Physical Examinations, laboratory or x-ray services from a **Non-Preferred Provider**, the benefit is limited to:

- \$300 for the Employee and \$300 for the Spouse **for each occurrence of a Routine Physical Examination.**
- \$200 for the Child – **Active Plan Only**

Routine Physical Examinations, laboratory and/or x-rays by a **Non-Preferred Provider** for **Retired Plan Dependent Children** are not covered by the Plan. *Certain* Preventive Care Services by a Preferred Provider may be covered as outlined above.

Hospital Emergency Room Services – Direct Payment Plan Only

If you have an **emergency medical condition** that requires you to go to an **outpatient hospital emergency room**, the Plan will apply the same **copayment** and **coinsurance** on the **outpatient hospital emergency room services** regardless of whether you receive the services from a PPO Hospital or a Non-PPO Hospital.

An emergency medical condition is one that happens **suddenly and unexpectedly** and is of a sufficient severity (including pain) that without immediate medical attention could be expected to result in:

- placing the health of an individual, or with respect to a **covered** pregnant woman (**excluding a dependent child**), the health of the woman or her unborn child in **jeopardy**
- Likely to cause long-term or permanent impairment to bodily functions, or death
- Likely to cause long-term or permanent damage of any bodily organ or part

With respect to a **covered** pregnant woman (**excluding a dependent child**) **who is having contractions**:

- that there is not enough time for a safe transfer to another hospital before delivery, or
- that transfer may pose a threat to the health or safety of the woman or the unborn child

Even though the Act requires that the Plan apply the same copayment and coinsurance on a claim for **outpatient hospital emergency room services** regardless of whether you use a PPO or Non-PPO Hospital, you should understand that using a Non-PPO hospital means that **you** pay more of the charges. There is no contractual requirement for a Non-PPO hospital to reduce the billed charges as there is if you use a PPO hospital. The example below illustrates how the calculations would work.

EXAMPLE OF PPO HOSPITAL VS. NON-PPO HOSPITAL EMERGENCY ROOM DIRECT PAYMENT PLAN

		<i>Preferred Provider Allowed Amount</i>	<i>Non-Preferred Provider Allowed Amount</i>
Billed Charges	\$5,000	\$3,500.00	\$5,000.00
Less Emergency Room Copayment		\$100.00	\$100.00
Subtotal		\$3,400.00	\$4,900.00
Less Deductible (if any remaining)		\$150.00	\$150.00
Subtotal		\$3,250.00	\$4,750.00
Plan pays 80%		\$2,600.00	\$3,800.00
Patient Pays 20%		\$650.00	\$950.00

As you see in the example, when a PPO hospital is used, the “allowed amount” is lower than a Non-PPO hospital. The difference between the “allowed amount” and the “billed amount” when you use a PPO hospital is a **discount** and the **savings is passed on to you reducing your share of cost on the claim.**

Active Kaiser Permanente Plan Members

Your benefits are changing September 1, 2011. Included with this Important Announcement is a Kaiser Benefit Summary showing the new deductible, copayments and/or coinsurance for September 1, 2011. You will also have the no cost Preventive care benefits **and other required changes under the Act**. For more information about your Kaiser Plan, call Kaiser Permanente Member Services at the telephone number located on your Kaiser Plan ID card.

Retired Kaiser Permanente Plan Members

Your benefits remain the same with the exception of the addition of no cost Preventive care benefits **and other required changes under the Act**. For more information about your Kaiser Plan, call Kaiser Permanente Member Services at the telephone number located on your Kaiser Plan ID card.

Internal and External Review of Coverage Determination – Direct Payment Plan

The Trust Fund currently provides *internal* claim appeal procedures for Plan Participants who request a review of a denial of benefits if they believe the denial is incorrect.

Effective **September 1, 2011**, the Act requires Participants be given an opportunity to have an internal as well as an **external** appeal of a denial which will be done by an independent review organization but is limited to denials for services that were considered not medically necessary.

External Review of Coverage Determination Kaiser Permanente Plan

For more information about the Kaiser Permanente Plan external claims review, call Member Services at Kaiser Permanente.

Notice About the Early Retiree Reinsurance Program (ERRP)

You are a Plan Participant, or are being offered the opportunity to enroll as a Plan Participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program (ERRP). The ERRP is a Federal program established under the Act. Under the ERRP, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on **January 1, 2014**.

Under the ERRP, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in Plan Participants' premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs. If the plan sponsor chooses to use the ERRP reimbursements in this way, you, as a Plan Participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and the plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the ERRP reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

**Grandfathered
Kaiser Permanente Plan and the Direct Payment Plan**

Being a grandfathered health plan means that a plan is not **required** to include certain consumer protections of the Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain **other** consumer protections in the Act such as dependent coverage to age 26. Loss of grandfathered status means that the Plan will then be required to provide other consumer protections of the Act.

Because of the Direct Payment Plan benefit changes in January, 2011, the Direct Payment Plan lost its grandfathered status as of September 1, 2011 and is therefore implementing the required changes under the Act.

As mentioned previously, the Kaiser Permanente Plan retains its “grandfathered” status until June 2013; however, changes under the Act are being implemented for the Kaiser Permanente Plan effective September 1, 2011 **earlier than required under the Act.**

If there are questions about this Announcement or the Plan changes, contact the Trust Fund Office, Monday through Friday, 8:00 AM to 5:00 PM. You may also contact the Trust Fund Office via email at customerservice@norcalcementmasons.org.

Sincerely,

Board of Trustees
Cement Masons Health and Welfare Trust Fund
for Northern California

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

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan.

Insert #10
Place this Announcement in your Plan Booklet - September, 2007
July 15, 2011

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Special Enrollment Form
Extension of Coverage for Adult Children to Age 26
This form must be postmarked by August 31, 2011
Insert with the Summer, 2011 Cement Mixer

As explained in the Important Announcement, the Affordable Care Act provides for an Extension of coverage for eligible adult children to the age of 26 – the Age-26 Mandate. Complete this Special Enrollment Form for any eligible child who lost coverage, or who was denied coverage due to age or dependency restrictions, prior to September 1, 2011.

Special Enrollment Deadline is September 1, 2011.

Section I. Participant Information

Social Security Number _____ or, Health Care ID CM _____

First Name _____ Middle _____ Last _____

Mailing Address _____ City _____ State _____ Zip Code _____

Unless documents have been previously provided, you are required to mail the applicable document(s) below with this form to the Fund Office to substantiate **your relationship to your dependent(s)**:

- NATURAL CHILD:** Birth Certificate
ADOPTED CHILD: Birth Certificate and Legal adoption document
STEP-CHILD: Birth Certificate
FOSTER CHILDREN: Documentation that the child/children have been placed in your care as a foster child.

Write your social security number on each of the document(s) for identification purposes.

Section II. Adult Child Information

Full Name(First, MI, Last)	Sex M/F	Birth Date	Social Security No.	Relationship to Participant

Section III. Other Insurance

Do any of the children you are enrolling during the Special Enrollment Period have another employer sponsored:

Medical Plan No Yes **Prescription Drug Plan** No Yes

Dental Plan No Yes **Vision Plan** No Yes

If you answered "Yes" to the section III questions, please complete the following section. Use a separate piece of paper if you need additional room.

Type of Coverage	Name of Company	Address, City, State	Name of Insured
Medical Plan			
Prescription Drug Plan			
Dental Plan			
Vision Plan			

Enrollment forms arriving after the August 31, 2011 deadline will delay the effective date of coverage for the eligible child to the date the Enrollment Form arrives at the Trust Fund Office, so long as you are eligible that month.

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 accurate, to the best of my knowledge.

Signature _____ Date _____