STATEMENT OF AMENDMENT NO. 3
TO THE DIRECT PAYMENT PLAN
OF THE CEMENT MASONS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA
AMENDED AND RESTATED EFFECTIVE MARCH 1, 2015

The undersigned Chairman and Co-Chairman of the Board of Trustees of the Cement Masons Health and Welfare Trust Fund for Northern California hereby certify that the following changes to the Direct Payment Plan for Active and Retired Cement Masons were ratified at the regularly held meeting of June 22, 2018:

Effective January 1, 2019, Article 1, Definitions, Section 12.00 and Section 50.00 are amended by removing the language in strike-through and adding language in underlined as follows:

Section 12.00 The term **"Covered Charges"** or "Covered Expenses" as it relates to Article V., Subsections 4.b. and 4.e., inpatient Hospital expense at a Non-Participating Hospital means: Room, board and routine nursing charges up to an amount equal to the Hospital's lowest rate charged for semi-private or intensive care room accommodations, or 80% (85% if you participate in the Promise Program)of the lowest rate charged for private room accommodations.

Section 50.00 The term **"Premier Plan"** means the ~~$300~~250 individual and ~~$900~~750 family Deductible hospital-medical plan available to an Active Participant and his eligible Dependents if the Active Participant and his eligible spouse, if any complete the Healthy Structures Promise described in Article I., Section 29.00.

Effective January 1, 2019, Article V, Comprehensive Hospital-Medical Benefits for Participants and Eligible Dependents, Section 3 a.(2) is amended by removing the language in strike-through and adding language in underlined as follows:

(2) **Premier Plan:** If the Participant and his eligible spouse, if any, complete the Healthy Structures Promise and Election Form described in Article I., Section 30.00, each Eligible Individual is responsible for the first ~~$300~~ $250 of Covered Expenses. This Deductible is an out-of-pocket cost for Covered Expenses incurred during any one Plan Year before Comprehensive Hospital-Medical Benefits become payable. When a total of ~~$900~~ $750 in Deductible Covered Expenses has been satisfied by covered family members during any one Plan Year, the Plan will waive any further Deductible amount for that family during the remainder of the Plan Year. This lower Deductible is called the "Premier Plan". If an eligible Active Participant or his eligible spouse, if any, fails to comply with all commitments in the Healthy Structures Promise, the Active Participant and his eligible Dependents will be responsible for the Deductible amount described in Subsection 3.a.(1).

The Deductible will not apply to the following:

(a) Preventive Care Services mandated by law or regulation **when a Participating Provider or Hospital is used.**

(b) Routine Physical Examinations.

(c) Primary care physician Office Visits when a Participating Provider is used.

Effective January 1, 2019, Article V, Comprehensive Hospital-Medical Benefits for Participants and Eligible Dependents, Section 3b.(1) is amended by removing the language in strike-through and adding language in underlined as follows:

(1) Each Eligible Individual is responsible for the first ~~$300~~ $250 of Covered Expenses. This Deductible is an out-of-pocket cost for Covered Expenses incurred during any one Plan Year before Comprehensive Hospital-Medical Benefits become payable. When a total of ~~$900~~ $750 in Deductible Covered Expenses has been satisfied by covered family members during any one Plan Year, the Plan will waive any further Deductible amount for that family during the remainder of the Plan Year.

The Deductible will not apply to the following:

(a) Preventive Care Services mandated by law or regulation **when a Participating Provider or Hospital is used.**

(b) Physician Office Visits **when a Participating Provider is used.**

(c) Routine Physical Examinations.

Effective January 1, 2019, Article V, Comprehensive Hospital-Medical Benefits for Participants and Eligible Dependents, Section 4 (a) and Section 4 (e) (1), and Section 4 (g) (c) (1) and Section 4 (h) subsections (1) and (2) are amended by removing the language in strike-

a. **Benefits for Confinement in a Participating Hospital**
If an Eligible Individual is confined in a Participating Hospital with the approval of the Professional Review Organization (PRO), the Fund will, subject to all other Plan provisions, pay the Participating Hospital 80% of the first $15,000 (85% if you participate in the Promise Program) of the negotiated contract rate and 100% of that negotiated contract rate thereafter for all Medically Necessary services including, but not limited to, room, board and routine nursing care.

e. **Exceptions to the Preferred Provider Plan**
(1) If an Eligible Individual **who does not reside** within the Fund's Preferred Provider Plan Service Area is confined in a Non-Participating Hospital with the approval of the PRO, the Fund will, subject to all Plan provisions, pay 80% (85% if you participate in the Promise Program) of the first $15,000 of **Covered Charges** (as defined in Article I., Section 12.00) and 100% of **Covered Charges** thereafter for all Medically Necessary services including, but not limited to, room, board and routine nursing care.

g. **Utilization Review**

(1) If an Eligible Individual is admitted to a Non-Participating Hospital and a Pre-Admission Review is not obtained, the Participant will, subject to all other Plan provisions, be responsible for an additional

coinsurance of 20% (15% if you participate in the Promise Program) of the first $10,000 of **Covered Charges** whether or not the PRO has conducted a Retrospective Review and determined that the confinement was Medically Necessary. This additional coinsurance is over-and-above the usual coinsurance stated in Subsections 4.b. or 4.e. and does not count towards the Plan Year Out-of- Pocket Maximum.

h. **Other Covered Expenses**

(1) For Covered Expenses incurred at a **Participating Provider or the outpatient department of a Participating Hospital,** the Fund will, subject to all other Plan provisions, pay 80% (85% if you participate in the Promise Program) of the negotiated contract rate, **except:**

(a) **For Preventive Care Services:** The Fund will pay 100% of the negotiated rate and will not be subject to the Plan Copayment or annual Deductible.

(b) **Active Participants and Eligible Dependents:** For Physician Office Visits, the Fund will, subject to all other Plan provisions, pay 100% of the negotiated rate after a $20 Physician Office Visit Copayment.

(c) **Retired Participants and Eligible Dependents:** For Physician Office Visits, the Fund will, subject to all other Plan provisions, pay 100% of the negotiated rate after a $20 Physician Office Visit Copayment.

(2) For Covered Expenses incurred at a **Non-Participating Provider or the outpatient department of a Non-Participating Hospital,** the Fund will, subject to all other Plan provisions, pay the **lesser** amount of the actual charge **or** 50% of the **Allowed Charge, except**:

(a) The Fund will pay for **Emergency Services** at 80% (85% if you participate in the Promise Program) of the Allowed Charge for outpatient services within the emergency department of a Non-Participating Hospital. This includes charges made by the Non-Participating Hospital, the Physician's professional fees and professional ambulance services.

(b) **Active Participants and Eligible Dependents:** For Physician Office Visits, the Fund will, subject to all other Plan provisions, pay 50% of the Allowed Charge after a $20 Physician Office Visit Copayment.

(c) **Retired Participants and Eligible Dependents:** For Physician Office Visits, the Fund will, subject to all other Plan provisions, pay 50% of the Allowed Charge after a $20 Physician Office Visit Copayment.

Effective January 1, 2019, Article V, Comprehensive Hospital-Medical Benefits for Participants and Eligible Dependents, Section 4 (g), Subsection (c)(1), and Subsection j. are amended by removing the language in strike-through and adding language in underlined as follows:

(1) If an Eligible Individual is admitted to a Non-Participating Hospital and a Pre-Admission Review is not obtained, the Participant will, subject to all other Plan provisions, be responsible for an additional coinsurance of 20% (15% if you participate in the Promise Program) of the first

$10,000 of **Covered Charges** whether or not the PRO has conducted a Retrospective Review and determined that the confinement was Medically Necessary. This additional coinsurance is over-and-above the usual coinsurance stated in Subsections 4.b. or 4.e. and does not count towards the Plan Year Out-of- Pocket Maximum.

j. **Pre-Authorization Review for Outpatient Services**
If an Eligible Individual does not obtain a Pre-Authorization Review from the Care Counselor prior to receiving non-emergency outpatient treatment to determine the Medical Necessity of the Covered Expenses listed below, the Participant will, subject to all other Plan provisions, be responsible for an additional 20% (15% if you participate in the Promise Program) coinsurance of the Allowed Charge. This additional coinsurance does not count towards the Plan Year Out-of-Pocket Maximum. Services requiring Pre-Authorization include:
(1) Diagnostic tests (e.g. MRI, PET and CT scans);
(2) Physical therapy visits;
(3) Durable Medical Equipment when the charges exceed $500;
(4) Chemotherapy or radiation;
(5) Genetic testing (e.g. amniocentesis);
(6) Sleep study;
(7) Arthroscopy, cataract or colonoscopy surgery; **and**
(8) Any routine cost, services and supplies associated with an "approved clinical trial".

Effective January 1, 2019, Article VII, Drug Benefits, Section 3, Subsection (1)(a)(1), Subsection (1)(c)(1), Subsection (2)(a)(1), and Subsection (2)(c)(1) are amended by removing the language in strike-through and adding language in underlined as follows:

(1)(a)(1) Premier Plan: For Formulary generic Drugs, the cost of the prescription less a **regular** copayment of $5 ~~$10~~ for up to a 30-days' supply **for the initial fill plus the first 2 refills.** This **regular** copayment is payable by the Eligible Individual to the Contracting Pharmacy. ~~Any additional refills obtained at a retail Contracting Pharmacy will be subject to the cost of the prescription less a regular copayment of $20 for up to a 30-days' supply.~~ This **regular** copayment is payable by the Eligible Individual to the Contracting Pharmacy. **If the Eligible Individual is prescribed a Drug not on the Formulary list, he will pay the full cost of the Drug.**

Basic Plan: For Formulary generic Drugs, the cost of the prescription less a **regular** copayment of $10 for up to a 30-days' supply **for the initial fill plus the first 2 refills.** This **regular** copayment is payable by the Eligible Individual to the Contracting Pharmacy. Any additional refills obtained at a retail Contracting Pharmacy will be subject to the cost of the prescription less a **regular** copayment of $20 for up to a 30-days' supply. This **regular** copayment is payable by the Eligible Individual to the Contracting Pharmacy. **If the Eligible Individual is prescribed a Drug not on the Formulary list, he will pay the full cost of the Drug.**

(1)(c)(1) Premier Plan: For Formulary generic Drugs, the cost of the prescription less a **regular** copayment of $10 ~~$20~~ for up to a 90-days' supply. This **regular** copayment is payable by the Eligible Individual to the Contracting Pharmacy. **If the Eligible Individual is prescribed a Drug not on the Formulary list, he will pay the full cost of the Drug.**

Basic Plan: For Formulary generic Drugs, the cost of the prescription less a **regular** copayment of $20 for up to a 90-days' supply. This **regular** copayment is payable by the Eligible Individual to the Contracting Pharmacy. **If the Eligible Individual is prescribed a Drug not on the Formulary list, he will pay the full cost of the Drug.**

Date: December 14 2018

Brian Gardner, Chairman

Greg Levy, Co-Chairman