CEMENT MASONS HEALTH AND WELFARE TRUST FUND
ACTIVE CEMENT MASONS AND THEIR ELIGIBLE DEPENDENTS
EFFECTIVE JANUARY 1, 2014

COMPARISON OF BENEFIT PLANS

PLAN FEATURES	DIRECT PAYMENT PLAN	KAISER PERMANENTE
When You Can Change Plans	You are free to change plans (from Direct Payment Plan to Kaiser Permanente or vice versa) twice in a calendar year. You and your eligible dependents may not split coverage – that is, you may not enroll in the Direct Payment Plan and your dependents enroll in Kaiser Permanente. To change medical plans, request an Active Plan Application Form from the Fund Office or your Local Union or go to our website, www.norcalcementmasons.org, to print or order the form on-line.	
Type of Plan	The Plan provides traditional, fee-for-service medical benefits and offers higher coverage when you use Anthem Blue Cross Advantage PPO network providers and receive prior authorization if you are required to do so.	Care is provided through physicians or medical staff at a Kaiser Permanente facility located in the member's service area.
Geographical Area Covered	Expenses incurred outside the United States and its Territories are covered if due to Emergency Services. If the expense is covered, normal benefits will apply.	You may enroll in Kaiser Permanente if you live or work within Kaiser Service Area. 80% payable after deductible for worldwide emergency coverage for unforeseen illness or injury. Waived if admitted.
Choice of Physicians Specialized Care In-Network Specialized Care Outside Network	Unlimited. You select any specialist but to lower your out-of-pocket expense, use an in-network provider. Contact Pacific Health Alliance (PHA) at 1-855-754-7271 to discuss the different provider options available in your area, the various costs for services you need and whether the services require pre-authorization by PHA.	Members must use a Kaiser Permanente Physician. Self-referral to specialists such as psychiatry and OB/Gyn. Your Kaiser Permanente physician refers you to other specialists. Covered after coinsurance and copayments are met if a Kaiser Permanente Physician refers you to outside specialist.
******Pre-Authorization Requirement For Outpatient Services	Pre-authorization from PHA is required for some non-emergency related outpatient services such as surgeries, MRI, CT scans, durable medical equipment, sleep study, chemotherapy, physical therapy and genetic testing 20% penalty of payable charges for non-compliance.	Referral is required from a Kaiser Permanente Plan Physician.
Healthy Structures Participant Promise Program	You are automatically enrolled in the higher deductible Basic Plan when you initially become eligible for benefits but have an option to participate in the Healthy Structures Participant Promise Program during initial eligibility period and annually during open enrollment period. If you participate in the Participant Promise Program, you will be enrolled in the lower deductible Premier Plan (see Annual Deductible category below for deductible amounts).	
Annual Deductible	Basic Plan: $1,000 per individual, $3,000 per family per Plan Year. Premier Plan: $300 per individual, $900 per family per Plan Year. Plan Year means January 1 – December 31. Deductible amount applied in October, November and December will be carried forward to following Plan Year.	Premier Plan: $300 per individual, $900 per family per Calendar Year. Basic Plan: $1,000 per individual, $3,000 per family per Calendar Year.
Annual Maximum	None. Some restrictions apply. See Hearing Aids and Chiropractic Care.	None. Some restrictions apply.
Annual Out-of-Pocket Expense Maximum	$3,000 per individual, $6,000 per family for services by Anthem Blue Cross providers including your Plan deductible, copayment and coinsurance. Out-of-Pocket does not include any Plan deductible, copayment and coinsurance applied to non-Anthem Blue Cross providers, penalties for not using an Anthem Blue Cross hospital, not obtaining a Utilization Review for inpatient hospitalization or Pre-Authorization Review for outpatient services, Plan exclusions and limitations.	$3,000 per individual up to $6,000 per family per Calendar Year.

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Inpatient Hospital Medical/Surgery Mental Health or Substance Abuse	Subject to deductible. Anthem Blue Cross Hospital - 80% of the first $15,000 of negotiated rates, 100% thereafter. Non-Anthem Blue Cross Hospital – 50% of first $15,000 of allowed charges, 100% thereafter. **Exception:** For emergencies and participants residing outside of service area, benefits are payable at 80% of first $15,000 of allowed charges, 100% thereafter. For pregnancy/delivery, you will be responsible for additional $1,000 of allowed charges if you do not participate in Anthem Blue Cross' Future Moms Program. Call 1-866-664-5404 to enroll or for more information.	Subject to deductible. 80% payable for all covered benefits and services at Kaiser Permanente medical facilities.
Total Hip or Knee Replacement Surgery	Same as Medical/Surgery above but subject to $30,000 Maximum Allowed Charges (MAC) for hospital charges (not including professional charges) if you do not use an Anthem Blue Cross "**Designated Hospital**" approved by the Plan.	
Skilled Nursing	Same as Medical/Surgery above.	80% payable for up to 100 days per Calendar Year.
Utilization Review	Automatic part of Plan procedures when admitted to a participating hospital. Required for most inpatient stays or extended care admissions. 20% penalty of 1st $10,000 payable charges for non-compliance.	Automatic part of Plan procedures.
Emergency Room Outpatient Hospital	Subject to deductible. Copayment waived under certain circumstances. Anthem Blue Cross Hospital - 80% of negotiated rate after $100 copayment. Non-Anthem Blue Cross Hospital - 80% of allowed charges after $100 copayment.	Subject to deductible. 80% payable.
Outpatient Hospital Care (Facility Charges)	Subject to deductible. Anthem Blue Cross Hospital - 80% of negotiated rates. Non-Anthem Blue Cross Hospital – 50% of allowed charges.	Subject to deductible. 80% payable for most outpatient services.
******Outpatient Hospital (Facility Charges) For Arthroscopic, Cataract, Colonoscopy	Subject to deductible. Anthem Blue Cross Hospital - 80% of negotiated rates and subject to Maximum Allowed Charges (MAC) below. Exception: The MAC will not apply if you use an Anthem Blue Cross "**Value Based Ambulatory Surgery Center.**" Non-Anthem Blue Cross Hospital – 50% of allowed charges and subject to MAC below. You will be responsible for any amounts over the MAC for the procedures listed below. Arthroscopy $6,000 * Cataract $2,000 * Colonoscopy $1,500	Subject to deductible. 80% payable for most outpatient services.
Ambulatory Surgical Facility	Subject to deductible. Anthem Blue Cross Facility - 80% of negotiated rate. Non-Anthem Blue Cross Facility - $500 maximum allowable charges regardless of procedure.	Subject to deductible. 80% payable at a Kaiser Permanente medical facility.

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Home Health Care	Subject to deductible. 80% of negotiated rate. Must be pre-authorized by Anthem Blue Cross of California.	100% payable up to 100 2-hour visits per Calendar Year when authorized by Plan physician for part-time, intermittent care.
Hospice Care	Subject to deductible. 80% of negotiated rate. Must be pre-authorized by Anthem Blue Cross of California.	100% payable when selected as alternative to traditional services and authorized by a Plan physician.
Physician Office Visit	Subject to deductible and $20 copayment per visit. Anthem Blue Cross Physician - 100% of negotiated rate. Non-Anthem Blue Cross Physician – 50% of allowed charge.	No deductible. $25 copayment per visit. Specialized Care - $45 copayment per visit.
Outpatient Mental Health Visit	Subject to deductible and $20 copayment per visit. Anthem Blue Cross Physician - 100% of negotiated rate. Non-Anthem Blue Cross Physician – 50% of allowed charge.	No deductible. Individual session - $25 copayment per visit. Group Session - $12 copayment per visit.
**Surgery Physician Fee	Subject to deductible. Anthem Blue Cross Provider - 80% of negotiated rate. Non-Anthem Blue Cross Provider - 50% of allowed charge. Exception: Outpatient Emergency Room Physician services payable at 80% of allowed charge.	Subject to deductible. Inpatient - 80% payable. Outpatient - 80% payable.
**Diagnostic Lab Tests, X-Ray, MRI & CT Scan	Subject to deductible. Anthem Blue Cross Provider - 80% of negotiated rate. Non-Anthem Blue Cross Provider - 50% of allowed charge.	Subject to deductible. $10 copayment per encounter. $50 copayment per procedure for MRI, CT and PET scans.
Physical Exam Well Baby	The following limits apply to out-of-network providers only. For in-network providers, see the row titled "Preventive Care Services". **Member or Spouse** - $300 maximum per EXAM, no deductible. **Child older than age 2** - $200 maximum per EXAM, no deductible. Well Baby charges for dependent children up to age 2 are payable as office visit and not subject to the $200 maximum.	No deductible. Adult - $25 copayment per visit. Children up to 23 months old/Prenatal – 100% payable.
Preventive Care Services	Anthem Blue Cross Provider - 100% of negotiated rate, no deductible, copayment or coinsurance. Non-Anthem Blue Cross Provider - Subject to deductible. 50% of allowed charge, after applicable copayment.	100% payable.
Outpatient Substance Abuse Treatment	Subject to deductible. Anthem Blue Cross Facility - 80% of negotiated rate. Non-Anthem Blue Cross Facility - 50% of allowed charge.	No deductible. Individual session - $25 copayment per visit Group Session - $5 copayment per visit
Chiropractic Benefits	Subject to deductible. Visits: $40 allowance per day up to 40 visits per Plan Year. X-rays: $300 maximum allowance per Plan Year.	$15 copayment per visit up to 30 visits per Calendar Year. $50 annual benefit for appliance. Radiological x-rays as authorized.
**Physical Therapy Occupational Therapy	Subject to deductible. Must be prescribed by a physician. Anthem Blue Cross Provider - 80% of negotiated rate. Non-Anthem Blue Cross Provider - 50% of allowed charge.	Subject to deductible. $25 copayment per visit.
Hearing Aids/Device	Subject to deductible. Must be prescribed by a physician. $1,000 maximum payable per ear/device every 36 months.	$20 copayment for hearing test only – no deductible. Hearing aids/device not covered.
Ambulance	Subject to deductible. Anthem Blue Cross Provider - 80% of negotiated rate. Non-Anthem Blue Cross Provider - 80% of allowed charge.	Subject to deductible. 80% payable.

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**Durable Medical Equipment	Subject to deductible. Must be prescribed by a physician. Anthem Blue Cross Provider - 80% of negotiated rate. Non-Anthem Blue Cross Provider - 50% of allowed charge.	No deductible. 80% payable when prescribed by a Plan physician and in accordance with Health Plan DME formulary guidelines.
Death, Accidental Death and Dismemberment	Benefits will be provided whether you enroll in Direct Payment Plan or Kaiser Permanente Plan. **Employee Death:** $10,000 plus additional $10,000 if death is a result of an accident. **Spouse Death:** $5,000 **Child Death:** $100 for age 24 hours but less than 6 months old; $500 for age 6 months but less than 26 years old. **Employee Injury/Dismemberment:** $5,000 to $10,000 depending upon part or parts of body.	
Dental Care	Benefits provided through Fund whether you enroll in Direct Payment Plan or Kaiser Plan. Fund offers three optional Dental Plans - see attached Dental Plans Comparison. **1.** Delta Dental Plan of California - refer to Group #9525-0001. Toll-Free No.: 1-888-335-8227. **2.** DeltaCare USA - refer to Group #05566-0001. Toll-Free No.: 1-800-422-4234. **3.** Pacific Union Dental - refer to Group #95450. Toll-Free No.: 1-800-999-3367.	
Vision Care	"Signature Choice Plan" provided through Vision Service Plan "VSP" whether you are enrolled in the Direct Payment Plan or Kaiser Permanente. Exam and Lenses: Payable every calendar year Frames: Every other calendar year Deductible: $20 Exam and $20 Lenses/Frames. Refer to Group 00877000, Division 10, Class 10. Toll-Free No.: 1-800-877-7195	In addition to VSP benefits provided through Fund (see Direct Payment Plan), Kaiser provides benefit for an eye exam only. You pay $20 copayment per exam – no deductible.
Prescription Drugs	OptumRx benefits provided through Fund. **Drugs must be on the list of <u>Formulary Covered Drugs</u>.** You pay the full cost if you take a drug that is not on the Formulary Covered Drugs and not pre-authorized by OptumRx. Call 1-800-797-9791 for a copy of the formulary. **Retail** – Participant pays copayment below per prescription. 30 day supply maximum per prescription. Generic - $10 * Brand Name - $25 You pay double copayment above after 3rd fill for drugs that can be purchased through Mail Order. **Mail Order** – Participant pays copayment below per prescription. 90 day supply maximum per prescription. Generic - $20 * Brand Name - $50 Mail Order is preferred for maintenance drugs.	<u>Retail</u> – Participant pays copayment below per prescription. 30 day supply maximum per prescription. Generic - $15 Brand Name - $30 <u>Mail Order</u> – Participant pays copayment below per prescription. 100 day supply maximum per prescription. Generic - $30 Brand Name - $60 Prescriptions written by non-Kaiser physicians are not covered.
Toll-Free Numbers	**1-888-245-5005**	**1-800-464-4000; 1-800-788-0616 (Spanish)** Refer to Group 500-0000 for Premier Plan, 500-0002 for Basic Plan

**** - Pre-authorization from PHA is required. If you do not obtain a pre-authorization, your coinsurance will be increased by 20%. Contact Pacific Health Alliance (PHA) at 1-855-754-7271 for more information.**

This comparison of benefits is intended only as a summary of the benefits provided by each plan. All exclusions and limitations of benefit coverage have not been included and may vary slightly from each to plan. The contents of this comparison are not to be construed or accepted as a substitute for the provisions of the Fund's Rules and Regulations or Kaiser's contract. Revised: 12/12/2013

CEMENT MASONS HEALTH AND WELFARE TRUST FUND
COMPARISON OF DENTAL PLANS EFFECTIVE JANUARY 1, 2014

Plan Features	Delta Dental of California		Pacific Union Dental	DeltaCare USA
	Delta Dental Premier	*Delta Dental PPO*		
Type of Plan	**Traditional FEE-FOR-SERVICE Plan.** Dental procedures paid according to a Table of Allowances. You pay the difference between the allowance and the dentist's fees.	**PPO Plan.** Dentists in the Delta Dental PPO plan negotiate fees that are even lower than the Delta Dental Premier plan. Dental procedures paid according to a Table of Allowances. You pay the difference between dentist's fees and allowance.	**Pre-paid HMO type Plan.** You select a Pacific Union dentist who provides all services including referrals to Specialists.	**Pre-paid HMO type Plan.** You select a PMI dentist who provides all services including referrals to Specialists.
Area Covered	More than 9,000 Northern California Delta Dental Premier dentists.	For list of PPO dentists in your area, call Delta Dental at toll free number 1-800-765-6003. (Network is limited).	Dental Offices throughout Northern California. Call 1-800-999-3367 for a Pacific Union dentist in your area.	Dental Offices throughout Northern California. Call 1-800-422-4234 for a DeltaCare USA dentist in your area.
Choice of Dentists	Any dentist, however, you pay less out-of-pocket costs when you use a Delta Dental Premier dentist because fees are pre-negotiated and dentist cannot charge more than the pre-negotiated amount.	Visit a Delta Dental PPO dentist for lower out-of-pocket costs. You are free to use any dentist though you pay lower out-of-pocket costs when you use a Delta Dental Premier dentist and even lower costs when you use a Delta Dental PPO dentist.	Pacific Union dentist only. All services and referrals must be provided by a Pacific Union dentist. No benefits will be paid if dental services are performed by other than a Pacific Union dentist.	DeltaCare USA dentist only. All services and referrals must be provided by a DeltaCare USA dentist. No benefits will be paid if dental services are performed by other than a DeltaCare USA dentist.
Annual Deductible	$100 per person, $300 per family Diagnostic and preventative services not subject to Plan Year Deductible.	$100 per person $300 per family	None	None
Annual Maximum	$2,000 per person	$2,000 per person	No maximum	No maximum
Out of Pocket Costs	Dental procedures paid according to a Table of Allowance. You pay the difference between dentist's fees and allowance.	Dental procedures paid according to a Table of Allowance. You pay the difference between dentist's fees and allowance.	Minimal co-payments	Minimal co-payments
Orthodontic Benefits	Not Covered	Not Covered	Start up fee of $350. 00. Member's co-payment up to $2,250.00. Coverage for member, spouse and children starting at age 10.	Start up fee of $350.00. Coverage for adults is up to $1,800.00 and for children is up to $1,600.00.