

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
RETIRED CEMENT MASONS AND THEIR ELIGIBLE DEPENDENTS
EFFECTIVE APRIL 1, 2012

COMPARISON OF
BENEFIT PLANS

GENERAL INFORMATION	DIRECT PAYMENT PLAN	KAISER PERMANENTE PLAN (Non-Medicare Eligible)	KAISER PERMANENTE SENIOR ADVANTAGE ("Medicare Risk")
When You Can Change Plans	You are free to change plans 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 a Retired Plan Application Form and a Kaiser Senior Advantage Enrollment Form if you have Medicare 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, Service Area and Location of Facilities	<p>The Plan provides traditional, fee-for-service medical benefits and offers higher coverage when you use Anthem Blue Cross providers and receive prior authorization if you are required to do so. You may seek care from any hospital or physician you like.</p> <p>PLAN BENEFITS ARE REDUCED FOR MEDICARE ELIGIBLE PARTICIPANTS.</p>	<p>Kaiser Permanente is a direct service plan. You must live in the Kaiser Permanente Service Area to participate.</p> <p>Benefits and services must be obtained at Kaiser Permanente facilities unless referred by a Kaiser Permanente physician.</p>	<p>Kaiser Permanente is a direct service plan. There are NO DEDUCTIBLE required for covered benefits. You must live in the Kaiser Permanente Service Area to participate.</p> <p>Benefits and services must be obtained at Kaiser Permanente facilities unless referred by a Kaiser Permanente physician. Medicare will not pay for services received outside the Kaiser Senior Advantage area except for emergencies.</p>
Geographical Area Covered	Expenses incurred outside the USA 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 within Kaiser Service Area. 80% payable after deductible for worldwide emergency coverage for unforeseen illness or injury. Waived if admitted.	You may enroll in Kaiser Permanente if you live within Kaiser Service Area. 100% worldwide emergency coverage for unforeseen illness or injury after a \$50 copayment (waived if admitted).
Choice of Physicians Specialized Care In-Network Specialized Care Outside Network	<p>Unlimited. Use of Anthem Blue Cross physicians result in lower out-of-pocket expenses.</p> <p>You select any specialist but to lower your out-of-pocket expense, 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.</p>	<p>Each member may use any Kaiser Permanente Physician.</p> <p>\$45 copayment per visit – no deductible, for most Specialty Care Visits (consultations, exams, and treatment that are not Primary Care Visits, including all consultations, exams and treatment provided by Personal Plan Physicians who are not Primary Care Physicians).</p> <p>\$45 copayment per visit – no deductible, for outside specialist service if referred by a Kaiser Permanente Physician</p>	<p>Each member may use any Kaiser Permanente Physician.</p> <p>\$20 copayment for specialist service referred by your Kaiser Permanente Physician.</p> <p>\$20 copayment for outside specialist service if referred by a Kaiser Permanente Physician.</p>
**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, chemotherapy, physical therapy and genetic testing 20% penalty of payable charges for non-compliance.	Referral is required from a Kaiser Permanente Plan Physician.	Referral is required from a Kaiser Permanente Plan Physician.
Claim Form	None.	No claim forms except for out-of-plan emergency care.	
Annual Deductible	\$300 per individual, maximum of \$900 per family per Plan Year (September 1 – August 31). Does not apply to Prescription Drugs, Physical Exam and Preventive Care Services. Deductible amount applied in June, July and August will be carried forward to following Plan Year.	\$300 per individual, maximum of \$900 per family per Calendar Year.	None.

GENERAL INFORMATION	DIRECT PAYMENT PLAN	KAISER PERMANENTE PLAN (Non-Medicare Eligible)	KAISER PERMANENTE SENIOR ADVANTAGE ("Medicare Risk")
Annual Maximum Payable	None. Some restrictions apply. See Hearing Aids and Chiropractic Care.	None. Some restrictions apply. See Hearing Aids and Chiropractic Care.	None. Some restrictions apply. See Hearing Aids and Chiropractic Care.
Annual Out-of-Pocket Expense Maximum	\$3,000 per individual, \$6,000 per family for services by Anthem Blue Cross providers. Out-of-Pocket does not include Physician Visit or Emergency Room copayment, penalties for not using an Anthem Blue Cross hospital, not obtaining a Utilization Review for inpatient hospitalization or Pre-Authorization Review for outpatient services, 50% of the UC&R for charges by non-Anthem Blue Cross providers, Plan exclusions and limitations.	\$3,000 per individual up to \$6,000 per family per Calendar Year.	\$1,500 per individual up to \$3,000 per family per Calendar Year.
**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 covered charges and subject to MAC below. You will be responsible for any amounts over the MAC for these procedures: Arthroscopy - \$6,000 MAC Cataract Surgery - \$2,000 MAC Colonoscopy - \$1,500 MAC	Subject to deductible. 80% payable.	\$20 copayment at a Kaiser Permanente facility.
Outpatient Hospital Care (Facility Charges)	Subject to deductible. Anthem Blue Cross Hospital - 80% of negotiated rates. Non-Anthem Blue Cross Hospital – 50% of covered charges.	Subject to deductible. 80% payable.	\$20 copayment at a Kaiser Permanente facility.
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. Remember that if you use a Value Based Ambulatory Surgical Center, the MAC will not apply.	Subject to deductible. 80% payable.	\$20 copayment at a Kaiser Permanente medical facility.
Emergency Room Outpatient Hospital	Subject to deductible. Anthem Blue Cross Hospital - 80% of negotiated rate after \$100 copayment. Non-Anthem Blue Cross Hospital - 80% of covered charges after \$100 copayment. Copayment waived under certain circumstances.	Subject to deductible. 80% payable. Waived if admitted.	\$50 copayment at a Kaiser Permanente facility. Waived if admitted.
Physician Office Visit	Anthem Blue Cross Physician - 100% of negotiated rate less \$20 copayment per visit – no deductible. Non-Anthem Blue Cross Physician - subject to deductible. 50% of UC&R after \$20 copayment per visit.	No deductible. \$25 copayment per visit. Specialized Care - \$45 copayment per visit.	\$20 copayment per visit.

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Outpatient Mental Health Visit	Anthem Blue Cross Provider - 80% of negotiated rate – no deductible. Non-Anthem Blue Cross Provider – subject to deductible. 50% of UC&R after \$20 copayment per visit.	No deductible. Individual session - \$25 copayment per visit. Group Session - \$12 copayment per visit.	\$20 copayment per visit.
**Surgery Physician Fee	Subject to deductible. Anthem Blue Cross Provider - 80% of negotiated rate. Non-Anthem Blue Cross Provider - 50% of UC&R. Exception: Outpatient Emergency Room Physician services payable at 80% of UC&R.	Subject to deductible. 80% payable. Waived if admitted.	\$20 copayment for outpatient procedure.
**Diagnostic Lab Tests Diagnostic X-Ray CAT Scan, MRI	Subject to deductible. Anthem Blue Cross Provider - 80% of negotiated rate. Non-Anthem Blue Cross Provider - 50% of UC&R.	Subject to deductible. \$10 copayment per encounter. \$50 copayment per procedure for MRI, CT and PET scans.	100% payable.
Physical Exam	No deductible. 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. Not covered for dependent children.	No deductible. Adult - \$25 copayment per visit. Children up to 23 months old/Prenatal – 100% payable.	Adult - \$20 copayment per visit.
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 UC&R after applicable copayment.	100% payable.	100% payable.
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.	\$15 copayment per visit, 30 visits per calendar year. \$50 annual chiropractic appliance benefit. 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 UC&R.	Subject to deductible. \$25 copayment per visit.	\$10 copayment per visit.
**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 UC&R.	No deductible. 80% payable when prescribed by a Plan physician and in accordance with Health Plan DME formulary guidelines.	100% payable when prescribed by a Plan physician and in accordance with Health Plan DME formulary guidelines.
Ambulance	Subject to deductible. Anthem Blue Cross Provider - 80% of negotiated rate. Non-Anthem Blue Cross Provider - 50% of UC&R. Air ambulance may be covered if due to a life threatening condition.	Subject to deductible. 80% payable.	100% payable when medically necessary and authorized by a Kaiser Permanente Physician.
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.	Up to \$1,000 allowance per device, up to 2 devices every 36 months.

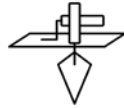
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Home Health Care	Subject to deductible. 80% of negotiated rate. Must be pre-authorized by Anthem Blue Cross of California.	100% payable up to 100 2-hour visits per Calendar Year when authorized by Plan physician for part-time, intermittent care.	100% payable.
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.	100% payable.
Inpatient Hospital Medical/Surgery Mental Health or Substance Abuse Total Hip or Knee Replacement Surgery Skilled Nursing	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 covered charges, 100% thereafter. Exception: For emergencies and participants residing outside of service area, benefits are payable at 80% of first \$15,000 of covered charges, 100% thereafter. 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. Same as Medical/Surgery above.	Subject to deductible. 80% payable.	No charge at Kaiser Permanente Facilities. Payment for services from doctors and hospitals out of Kaiser Permanente Service Area not contracting with Kaiser Permanente is limited to emergency services required before the member's medical condition permits transfer or travel to the nearest Kaiser Permanente health facility for care. The amount otherwise payable is reduced by any medical insurance benefits, except Medi-Cal. 100% for up to 100 days per benefit period when authorized by a Plan physician.
Utilization Review Inpatient Hospital	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.	Automatic part of Plan procedures.
Vision Care	Optional “Signature Choice Plan” provided through Vision Service Plan “VSP” for an additional monthly cost whether you are enrolled in the Direct Payment Plan or Kaiser Permanente. Exam and Lenses: Payable every 12 months. Frames: Payable every 24 months. Deductible: \$20 Exam and \$20 Lenses/Frames. Refer to Group 00877000, Division 12, Class 12. Toll-Free No.: 1-800-877-7195	No Charge for eye exam for refraction provided at a Kaiser Permanente medical facility.	\$20 copayment for exam provided at a Kaiser Permanente medical facility. \$150 eyewear allowance every 24 months when obtained at a Kaiser Permanente medical facility.
Dental Care	Optional benefits provided through Fund whether you enroll in Managed Health Care Plan or Kaiser Plan. Fund offers three optional Dental Plans for an additional cost - see attached Comparison of Dental Plans for more details: 1. Delta Dental - Choose any dentist but higher out-of-pocket cost if a non-Delta Dental dentist is used. Refer to Group #9525-0002. Toll-Free No.: 1-888-335-8227. 2. DeltaCare USA – a prepaid/Dental HMO Plan. Refer to Group #05566-0002. Toll-Free No.: 1-800-422-4234. 3. Pacific Union Dental – a prepaid/Dental HMO Plan. Refer to Group #95482. Toll-Free No.: 1-800-999-3367.		

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Prescription Drugs	<p>OptumRx benefits provided through Fund.</p> <p><u>MEDICARE PARTICIPANTS & DEPENDENTS</u> Participant pays copayment below. If you prefer brand name and a generic drug is available, you will be responsible for the difference in cost plus copayment.</p> <p>Retail – 30 day supply per prescription. Generic - \$10 Formulary Brand Name - \$25 Non-Formulary Brand Name - \$50 You pay double copayment above after 3rd fill for drugs that can be purchased through Mail Order.</p> <p>Mail Order – 90 day supply per prescription. Generic - \$20 Formulary Brand Name - \$50 Non-Formulary Brand Name - \$100</p> <p><u>NON-MEDICARE PARTICIPANTS & DEPENDENTS</u> Drugs must be on the list of Formulary Covered Drugs. 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.</p> <p>Participant pays copayment below: Retail – 30 day supply per prescription. Generic - \$10 Brand Name - \$25 You pay double copayment above after 3rd fill for drugs that can be purchased through Mail Order.</p> <p>Mail Order – 90 day supply per prescription. Generic - \$20 Brand Name - \$50</p>	<p>Retail – Participant pays copayment below per prescription. 30 day supply maximum per prescription. Generic - \$15 Brand Name - \$30</p> <p>Mail Order – Participant pays copayment below per prescription. 100 day supply maximum per prescription. Generic - \$30 Brand Name - \$60</p> <p>Prescriptions written by non-Kaiser physicians are not covered.</p>	<p>\$10 copayment for generic or \$20 copayment for brand name drug per prescription. 100 day supply maximum per prescription. Must be purchased at a Kaiser Plan Pharmacy.</p>
Toll-Free Numbers	1-888-245-5005	1-800-464-4000. Refer to Group 500-0001. 1-800-788-0616 (Spanish)	1-800-814-0888. Refer to Group 500-0001. 1-800-788-0616 (Spanish)

**** - 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 COVERAGES IS INTENDED ONLY AS A GENERAL DESCRIPTION OF EACH PLAN'S BENEFITS. EACH PLAN'S BROCHURE SHOULD BE CONSULTED FOR ADDITIONAL INFORMATION. THIS IS NOT A CONTRACT.

Revised 3/13/2012



**CEMENT MASONS HEALTH AND WELFARE TRUST FUND
COMPARISON OF DENTAL PLANS EFFECTIVE APRIL 1, 2012**

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 DeltaCare USA 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	\$100 per person \$300 per family	None	None
Annual Maximum	\$1,000 per person	\$1,000 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 copayments	Minimal copayments
Orthodontic Benefits	Not Covered	Not Covered	Start up fee of \$350.00. Member's copayment 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 children is up to \$1,600.00.