CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
RETIRED CEMENT MASONS AND THEIR ELIGIBLE DEPENDENTS
EFFECTIVE JANUARY 1, 2016

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	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. PLAN BENEFITS ARE REDUCED FOR MEDICARE ELIGIBLE PARTICIPANTS.	Kaiser Permanente is a direct service plan. You must live in the Kaiser Permanente Service Area to participate. Benefits and services must be obtained at Kaiser Permanente facilities unless referred by a Kaiser Permanente physician.	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. 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.**
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	Unlimited. Use of Anthem Blue Cross physicians result in lower out-of-pocket expenses. 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.	Each member may use any Kaiser Permanente Physician. $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). $45 copayment per visit – no deductible, for outside specialist service if referred by a Kaiser Permanente Physician	Each member may use any Kaiser Permanente Physician. $20 copayment for specialist service referred by your Kaiser Permanente Physician. $20 copayment for outside specialist service if referred by a Kaiser Permanente Physician.
******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. **Does not apply to Prescription Drugs, Physical Exam and Preventive Care Services.** Deductible amount applied in October, November and December will be carried forward to the following Plan Year.	$300 per individual, maximum of $900 per family per Calendar Year.	None.
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.

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Annual Out-of-Pocket Expense Maximum	$3,000 per individual, $6,000 per family for services by participating providers only or by non-participating providers for Emergency Services as mandated by the Patient Protection and Affordable Care Act. Out-of-Pocket expenses are your deductible, emergency room and physician office visit copayments and coinsurance. It does not include penalties for not using an Anthem Blue Cross hospital, penalties for not obtaining Utilization Review or Pre-Authorization Review, charges that are not covered by the Plan and charges that exceed the Plan's Maximum Allowed Charges.	$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 allowed 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 allowed 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 allowed charges after $100 copayment. Copayment waived under certain circumstances.	Subject to deductible. 80% payable. Waived if admitted.	$50 copayment at a Kaiser Permanente facility. Copayment waived if admitted.
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.

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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.
Outpatient Mental Health 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 allowed charges after $20 copayment per visit.	No deductible. Individual session - $25 copayment per visit. Group Session - $12 copayment per visit.	$20 copayment per visit.
Physical Exam	No deductible. Not covered for dependent children. The following limits apply to out-of-network providers only. For in-network providers, see "Preventive Care Services". **Member or Spouse** - $300 maximum per EXAM.	No deductible. Adult - $25 copayment per visit. Children up to 23 months old/Prenatal – 100% payable.	Adult - $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 allowed charge. Exception: Outpatient Emergency Room Physician services payable at 80% of allowed charge.	Subject to deductible. 80% payable. Waived if admitted.	$20 copayment for outpatient procedure.
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.	100% payable.
**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 allowed charge.	Subject to deductible. $10 copayment per encounter. $50 copayment per procedure for MRI, CT and PET scans.	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 allowed charge.	Subject to deductible. $25 copayment per visit.	$10 copayment per visit.
Ambulance	Subject to deductible. Anthem Blue Cross Provider - 80% of negotiated rate. Non-Anthem Blue Cross Provider - 80% of allowed charge. Air ambulance - 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.
**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.	100% payable when prescribed by a Plan physician and in accordance with Health Plan DME formulary guidelines.

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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 allowed charges, 100% thereafter. **Exception:** For emergencies and participants residing outside of service area, 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. Up to $2,000 penalty if Pre-Admission Review is not obtained when admitted to a non-participating hospital.	Automatic part of Plan procedures.	Automatic part of Plan procedures.
Vision Care	Optional "VSP Choice" provided through Vision Service Plan "VSP" for an additional monthly cost whether you are enrolled in the Direct Payment Plan or Kaiser Permanente. Frequency Deductible Exam: Once every calendar year $20 Lenses: Once every calendar year $20* Frames: Once every other calendar year $20* * - $20 total deductible for both if taken together 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. Optional "VSP Choice" provided through Vision Service Plan "VSP" for an additional monthly cost whether you are enrolled in the Direct Payment Plan or Kaiser Permanente.	$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. Optional "VSP Choice" provided through Vision Service Plan "VSP" for an additional monthly cost whether you are enrolled in the Direct Payment Plan or Kaiser Permanente.
Dental Care	Optional benefits provided through Fund whether you enroll in Direct Payment 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. **UnitedHealthcare Dental** – a prepaid/Dental HMO Plan. Refer to Group #95482 Toll-Free No.: 1-800-999-3367.		
Prescription Drugs	OptumRx benefits provided through Fund. **Annual Out-of-Pocket Maximum** - $1,000 per individual up to $2,000 per family. Out-of-Pocket expenses are the regular copayments you paid to Contracting Pharmacies only.	Retail – Participant pays copayment below per prescription. 30 day supply maximum per prescription. Generic - $15 Brand Name - $30 Mail Order – Participant pays copayment below per prescription.	$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.

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	MEDICARE PARTICIPANTS & DEPENDENTS 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. **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. **Mail Order** – 90 day supply per prescription. Generic - $20 * Formulary Brand Name - $50 Non-Formulary Brand Name - $100 **NON-MEDICARE PARTICIPANTS & DEPENDENTS** **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. 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. **Mail Order** – 90 day supply per prescription. Generic - $20 * Brand Name - $50	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. 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 12/29/2015

CEMENT MASONS HEALTH AND WELFARE TRUST FUND
COMPARISON OF DENTAL PLANS EFFECTIVE JANUARY 1, 2016

Plan Features	Delta Dental of California		UnitedHealthcare (UHC) 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 UHC 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 UHC 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.	UHC dentist only. All services and referrals must be provided by a UHC dentist. No benefits will be paid if dental services are performed by other than a UHC 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 $1,500.00. 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.