Cement Masons Trust Funds for Northern California
4160 Dublin Blvd. Suite 100, Dublin, CA 94568
Telephone: (707) 864-3300 • TOLL FREE (888) 245-5005 • FAX (925) 833-7301

*** OPEN ENROLLMENT PACKAGE***

THE DEADLINE TO ELECT DENTAL CHANGE OR ENROLL IN THE HEALTHY STRUCTURES PROGRAM IS DECEMBER 15, 2026.

THE ELECTION YOU MAKE WILL BE EFFECTIVE JANAURAY 1, 2027 THROUGH DECEMBER 31, 2027.

When you first become eligible, you are automatically enrolled in the;

- Medical through Basic Direct Payment Plan (Anthem Blue Cross)
- Dental through the Self-funded Delta Dental Plan,
- Vision through Vision Service Plan,
- Prescription drug coverage through Optum Rx.

Enclosed is your "Open Enrollment Packet" which includes the following information (Disponible en español a pedido):

- Enrollment Form
- Dental Enrolment Form
- Dental Comparison Sheet
- Healthy Structures Promise Program Election Form
- CHIP Notice
- WHCRA-HIPPA Notice

Available on Website or Upon Request:
https://www.norcalcementmasons.org/healthplanddocuments/

- **Summary Plan Description booklet is online at:**
- **Summary of Benefits Coverage**

HEALTHY STRUCTURES PROMISE PROGRAM ELECTION

When you elect to enroll in the Healthy Structures Promise Program you pay less:

	Individual	Family	Coinsurance
Basic Plan Deductible	$1,000	$3,000	20%
Kaiser Promise Program Deductible	**$300**	**$900**	**20%**
Direct Payment Promise Program Deductible	**$250**	**$750**	**15%**

**Coinsurance for out of network providers is 50% for both plans

If you elect to enroll in the Healthy Structures Promise Program Election you must complete the forms that correlate with the Plan you are or want to be enrolled in and follow the instructions.

Example: If you are enrolling or are enrolled in the Anthem Direct Payment Plan, you must complete the Direct Payment Plan Healthy Structures Promise Program packet.

⚠ You may opt to change your Medical Plan at any time though the calendar year but, are **limited to enrolling in the Promise Program during the Open Enrollment period**. Should you choose to change your Medical coverage at this time, **you will need to request a new Healthy Structures Promise Program Election Form that correlates with the Plan you are enrolling in**, from the Trust Fund Office.

ADDING A DEPENDENT

You must complete the Dependent Information section on the enclosed enrollment form.

It is Mandatory to Include:

- All dependent's birthdates and social security numbers
- If adding a spouse, we require a copy of the marriage certificate and
- If adding dependent child(ren), we require a copy of their birth certificate. (Hospital issued birth certificates are not acceptable)
- If any of your dependents are covered by another insurance, we require you to complete the Dual Coverage Questionnaire.

⚠ **IF YOU FAIL TO PROVIDE THE REQUIRED INFORMATION YOUR APPLICATION CAN NOT BE COMPLETED.**

Please complete your enrollment form(s) in full and return the required documents within **30 days** in order that we may promptly enroll you and your dependents.

If you have any questions or if you do not receive your medical, dental or prescription cards, please call the Fund office at the above number.

Eligibility Department

YOUR ENROLLMENT RESPONSIBILITY

It is your responsibility to keep your enrollment information current including adding and deleting Dependents, as in the case of a divorce (deleting) or a newborn child (adding). These changes must be made in writing. The eligibility of Dependents cannot be changed over the telephone.

REMEMBER TO SIGN AND DATE ANY FORMS SUBMITTED.

⚠ CAUTION

If you do not remove your former spouse, including any stepchildren, if applicable, from the Plan as of the date your divorce is final and the Fund pays any Claims for services on or after that date for your former spouse or stepchildren, you will be responsible for repaying the Fund the amount of the benefits paid on behalf of those ineligible individuals.

CEMENT MASONS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA
4160 Dublin Blvd, Suite 100
Dublin, CA 94568
Telephone: (707) 864-3300 or (888) 245-5005
Email Address: nccmenrollment@hsba.com

FUND OFFICE USE ONLY (536)
EFF. DATE:
HCID: HA
ELIGIBILITY CODE/GROUP NO.:

ACTIVE PLAN APPLICATION FORM

PARTICIPANT INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST	MIDDLE	LAST

RESIDENCE ADDRESS (not Post Office Box)	CITY	STATE	ZIP CODE

TELEPHONE NO.	LOCAL UNION	DATE OF BIRTH			GENDER	MARITAL STATUS
		MONTH	DAY	YEAR		
( )					☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED

BENEFIT HEALTH PLAN OPTIONS (You & your Dependents must be enrolled in the **same** Benefit Health Plan)

☐ **CEMENT MASONS DIRECT PAYMENT PLAN**

☐ **KAISER PERMANENTE** IF NOW OR A FORMER KAISER MEMBER, ENTER MEDICAL RECORD #:_____

DEPENDENT INFORMATION (List all eligible dependents; use reverse side if you need more space)

RELATIONSHIP	GENDER	FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM PARTICIPANT)	DATE OF BIRTH MO / DY / YR	SOCIAL SECURITY NUMBER	IF NOW OR PREVIOUSLY KAISER MEMBER, ENTER MEDICAL RECORD #
☐ SPOUSE ☐ DOMESTIC PARTNER	☐ MALE ☐ FEMALE				
CHILD	☐ MALE ☐ FEMALE				
CHILD	☐ MALE ☐ FEMALE				
CHILD	☐ MALE ☐ FEMALE				

I apply for health plan membership. I certify under penalty of perjury, under the laws of California that the information given in this form is true, correct, and complete to the best of my knowledge.

DATE:_____ PARTICIPANT'S SIGNATURE:_____

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

_____ DATE

_____ SIGNATURE REQUIRED FOR KAISER PERMANENTE PLAN

FUND OFFICE USE ONLY (please do not write in this space)

☐ NEW PARTICIPANT ☐ OPEN ENROLLMENT ☐ NEW DEPENDENT

☐ COBRA - DATE OF QUALIFYING EVENT_____

REMARKS:

DATE:_____ BY:_____

Revised 5/2025

Cement Masons Health & Welfare Trust Fund for Northern California
4160 Dublin Blvd. Suite 100, Dublin, CA 94568
Telephone: (707) 864-3300 • TOLL FREE (888) 245-5005 • FAX (925) 833-7301
norcalcementmasons.org

Dear Participant,

Information has been received indicating that you and/or your dependent(s) may be eligible under another insurance plan. In order to determine the primary carrier for your benefits, please answer the questions below. **All claims will be pending your reply to this questionnaire.** For further information on benefit coordination, please refer to your Health & Welfare SPD (pg.78). Please return this form as soon as possible.

Today's Date: _____

Member's Name: _____ ID#: _____

Is or was there other coverage for you or your dependent(s) other than coverage through No CA Cement Masons within the last 2 years? ☐ No ☐ Yes (if yes fill out **EACH SECTION** below)

---

1. Subscriber for other insurance: _____

SSN (for above subscriber): _____ D.O.B: _____

Employer Name: _____

---

3. Medical Insurance Name: _____ Policy/ID#: _____

Insurance's Phone#: _____Insurance's address: _____

_____

Effective Date: _____ Termination Date (if applicable): _____

List each person covered under the above plan and their relationship to the subscriber:

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

***If more room is needed, please use an additional page*

(Continued on Reverse Side)

4. Plan Type (choose one for each)

a) The subscriber is: ☐ Active Employee ☐ Retired ☐ COBRA ☐ Other _____

b) Medical plan is provided through: ☐ Employer ☐ Private/Individual ☐ State/Federal

c) The medical plan is an: ☐ HMO ☐ PPO ☐ Other: _____

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5. Is there a legal document that assigns primary health care coverage? ☐ Yes ☐ No

(Please ensure our office has a copy of these legal documents on file)

If yes, what is the relationship of the party with decreed responsibility? _____

6. Who has custody of the dependent child(ren)? _____

_____

Please include a copy of the front & back of the insurance card that the above information pertains to

I understand that it is illegal, and a felony in some states for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an enrollment request containing any false, incomplete, or misleading information. In some states, anyone found guilty of insurance fraud is subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature: _____ Date: _____

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Dublin, CA 94568
Telephone: (707) 864-3300 or (888) 245-5005
E-Mail Address: nccmenrollment@hsba.com

FUND OFFICE USE ONLY
EFF. DATE:
HCID: **HA**
ELIGIBILITY CODE/GROUP NO.:

ACTIVE & RETIRED PLANS DENTAL ENROLLMENT FORM

PARTICIPANT INFORMATION (Please print or type in black ink only)

SOCIAL SECURITY NUMBER	NAME: FIRST MIDDLE LAST				
RESIDENCE ADDRESS (not Post Office Box)	CITY			STATE	ZIP CODE
TELEPHONE NO. ( )	LOCAL UNION	DATE OF BIRTH MONTH	DAY	YEAR	GENDER ☐ MALE ☐ FEMALE / MARITAL STATUS ☐ SINGLE ☐ MARRIED

DENTAL PLAN OPTIONS

IMPORTANT: You and your Dependents must be enrolled in the same Dental Plan. Check only one box.

☐ **Delta Dental.** You may seek dental care from any dentist but, your out-of-pocket expense is lower if you use a participating Delta Dental dentist.

☐ **DeltaCare USA**. You must select a Dental Office from Delta Care Participating Dental Offices Directory:

Name of Dental Office: _____ Facility No.: _____

☐ **UnitedHealthcare Dental.** You must select a dentist or dental group from UnitedHealthcare Dental Provider Directory:

Name of Dentist: _____ Dentist No.: _____

DEPENDENT INFORMATION (List all eligible dependents to be enrolled. Use back page if more space needed.)

FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM EMPLOYEE)	DATE OF BIRTH MO / DY / YR	DEPENDENT RELATIONSHIP	FUND OFFICE USE ONLY
1.		SPOUSE	
2.		☐SON ☐DAUGHTER	☐STUDENT
3.		☐SON ☐DAUGHTER	☐STUDENT
4.		☐SON ☐DAUGHTER	☐STUDENT
5.		☐SON ☐DAUGHTER	☐STUDENT

I understand that once I have selected a Plan, I cannot change to another Plan until the next Open Enrollment. I agree to be bound by the benefits, deductions, co-payments, exclusions and other terms of the Plan group agreement. **Your application will not be accepted without your signature below. Please return this Enrollment Form to the Fund Office.**

Important: If you enroll in DeltaCare USA or UnitedHealthcare Dental, any dispute that may arise between you and the Dental Plan will be subject to binding arbitration.

Date:_____ Participant's Signature:_____

FUND OFFICE USE ONLY (Please do not write in this space)

☐ NEW EMPLOYEE ☐ OPEN ENROLLMENT

☐ COBRA - DATE OF QUALIFYING EVENT_____

REMARKS:

DATE:_____ BY:_____

CEMENT MASONS HEALTH AND WELFARE TRUST FUND
COMPARISON OF DENTAL PLANS EFFECTIVE JANUARY 1, 2026

Plan Features	Delta Dental of California		UnitedHealthcare Direct Compensation Dental	DeltaCare USA
	Delta Premier	**Delta Dental PPO**		
Type of Plan	**Traditional FEE-FOR-SERVICE Plan.** Dental procedures are 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 are paid according to a Table of Allowances. You pay the difference between dentist's fees and allowance.	**Pre-paid HMO type Plan**. No pre-selection is necessary for a UnitedHealthcare Direct Compensation dentist who provides all services including referrals to Specialists.	**Pre-paid HMO type Plan.** You select a DeltaCare 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 toll free at 1-888-335-8227.	For list of PPO dentists in your area, call Delta Dental at toll free number 1-888-335-8227 or use www.deltadentalins.com (Network is limited).	Dental Offices throughout Northern California. Call 1-800-999-3367 for a UnitedHealthcare Direct Compensation dentist in your area.	Dental Offices throughout Northern California. Call 1-800-422-4234 or use www.deltadentalins.com 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.	UnitedHealthcare Direct Compensation dentist only. All services and referrals must be provided by a UnitedHealthcare Direct Compensation dentist. No benefits will be paid if dental services are performed by other than a UnitedHealthcare Direct Compensation 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	$0 per person, $0 per family Diagnostic and preventative services not subject to Plan Year Deductible.	$100 per person, $300 per family Diagnostic and preventative services not subject to Plan Year Deductible.	None	None
Annual Maximum	$2,000 per person Diagnostic and Preventative Benefits provided by any dentist are not counted towards the annual maximum.	$2,000 per person Diagnostic and Preventative Benefits provided by any dentist are not counted towards the annual maximum.	No maximum	No maximum
Out of Pocket Costs	Diagnostic and Preventative Benefits are covered at 100% UCR. All other covered services are paid on the TOA. You pay the difference between dentist's fees and allowance.	Diagnostic and Preventative Benefits are covered at 100% UCR. All other covered services are paid on the TOA. You pay the difference between dentist's fees and allowance.	Minimal co-payments	Minimal co-payments
Orthodontic Benefits	$1,500 lifetime maximum for Active employees and their dependent children who have enrolled in the Trust's Promise Program.	Not Covered	Startup fee of $350.00. Ortho Retention (Removal of Appliances, Construction and Placement of Retainers) $150. Member's total copayment is $2,000.00 for 24 months of standard Ortho treatment. Coverage for member, spouse and Children starting at age 10.	Startup fee of $350.00. Coverage for adults is up to $1,800.00 and for children is up to $1,600.00.

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ANNUAL NOTICE: WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance apply.
If you would like more information on WHCRA benefits, call your plan administrator.

WHERE TO FIND HIPAA PRIVACY NOTICE FOR YOUR GROUP HEALTH PLAN

The HIPAA Privacy Notice pertains to the following group health plan benefits sponsored by this Health and Welfare Trust Fund

- *The self-funded Medical, Dental and Vision Plans*
- *Other health benefits regulated by HIPAA that are self-funded or self-administered*
- *COBRA Administration*

To obtain a copy of this Fund's HIPAA Notice of Privacy Practices write or call the Customer Service Department at: 4160 Dublin Blvd Ste 100, Dublin, CA 94568, 1-888-245-5005.

HIPAA Privacy Notices that pertain to the insured medical benefits offered by this Trust Fund can be obtained by contacting Kaiser Foundation Health Plan at 1-800-464-4000 and Cement Masons Health & Welfare Trust Fund for Northern California at 1-888-245-5005.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Cement Masons Trust Funds for Northern California

4160 Dublin Blvd. Suite 100 • Dublin, CA 94568
Telephone: (707) 864-3300 • TOLL FREE (888) 245-5005 • FAX (925) 833-7301

To: **All Active Participants Enrolled in the Direct Payment Plan**

Re: **Enroll or Renew Enrollment in the Direct Payment Premier Plan**

Date: July 2026

Dear Participant,

Our records indicate that you are either currently enrolled in the Direct Payment Plan's Basic Plan or in the Premier Plan and must renew your participation in the Promise Program. Your annual opportunity to participate in the Promise Program and enroll in the Premier Plan for the coming January 1 Plan Year starts today and continues through December 31, 2026. If you and your eligible spouse, if any, complete the requirements for the Promise Program, you will be enrolled in the Premier Plan effective January 1, 2027. If you choose not to participate in the Promise Program, you will be enrolled in the higher deductible Basic Plan during the entire Calendar Year of January 1 – December 31.

You have two choices:

- Direct Payment Premier Plan – lower deductible (you pay less when you need care)
- Direct Payment Basic Plan – higher deductible (you pay more when you need care)

✅ How to Get the Basic Plan

If you want to remain in, or revert to the Basic Plan.

- Do nothing.

If you want the Premier Plan for January 1, 2027, you must follow the steps below between now and December 31, 2026.

✅ How to Get the Premier Plan

Step 1: Fill out the enclosed Promise Form

- Read the form carefully.
- If you agree, sign and date it.
- Your spouse (if you have one) must also sign.
- Send it in by December 15, 2026

Step 2: Get a Free Health Check

- You and your spouse must get a free health screening.
- This must be done by December 31, 2026.

Step 3: Stay in the Program and stay connected

- **Open Enrollment:** To stay in the Premier Plan, you must renew every year, fill out a Promise Form, and get a screening each year. If you do not join now, you can try again during the next open enrollment.
- **Promise to Stay Connected.** We want to send you important updates. Please share your current email address or cell phone number, if you have one.

☑ **If you complete all the steps:**

- You will be in the Premier Plan (lower cost).

❌ **If you do NOT complete the steps:**

- You will be in the Basic Plan (higher cost) for the whole year.

💡 **Why Do This?**

The program helps you:

- Stay healthy
- Use lower-cost doctors and services
- Save money for you and the Trust Fund

We hope that you will participate and commit to take certain actions to improve your health and take extra steps as required by the Promise Program. By participating, we believe that your decision will save you and the Trust Fund thousands of dollars.

Important: Both you and your eligible spouse, if any, must agree to the requirements together and each must complete and sign the Promise Form and return it in order to participate in the Promise Program. Please read all the enclosed materials for more information about the Promise Program commitments and what you need to do in order to have the lower deductible Premier Plan.

🏠 **Did your address, phone number, or email change?**

Tell the Trust Fund Office right away. If your contact information is not current, you could lose your Premier Plan.

☎ Call the Trust Fund Office at **1-888-245-5005** if you have any questions.

Sincerely,
Board of Trustees

Instructions to Enroll:

The Healthy Structures Promise: A Simple Guide

The Healthy Structures Promise helps you learn about your health. When you know more, you can make good choices and stay healthy.

The Healthy Together Partnership means we work together to help you stay healthy.
If you and your spouse (if you have one) sign the Promise Form, you agree to do these things:

1. Get a **free** health screening by **December 31, 2026**.
2. Keep your contact information updated.
3. Share an email address or cell phone number so the Trust Fund Office can send you updates.
4. Call the Anthem 24/7 Nurse Line before you get outpatient care. NurseLine: 1-800-700-9184

When you and your spouse (if you have one) agree to the Promise, we agree to help by:

1. Giving you a **free** biometric health screening.
2. Helping you understand your results and what to do next.
3. Putting you in the lower deductible Premier Plan.

This program gives you tools to learn about your health, understand risks, and make smart choices.

Step 1: *Fill Out the Promise Form*

Read the Promise Form. If you and your spouse agree, do these things:

1. Fill out the form.
2. Sign and date it.
3. Mail it to the Trust Fund Office by **December 15, 2026.**

Joining the Promise Program is your choice. If you do not join, you will stay in the Basic Plan, which has a higher yearly deductible.

Step 2: *Get Your Free Health Screening*

You and your spouse must get a **free biometric health screening by December 31, 2026.**
This screening can find health problems early. Then you and your doctor can make a plan to help you stay healthy.

How to do Step 2: Schedule your biometric health screening

- You must be eligible for benefits when you schedule and get your biometric health screening. To check, call the Trust Fund Office at 1-888-245-5005. If you have Kaiser Permanente and want to switch to the Direct Payment Plan, call the Trust Fund Office first.
- You can get your biometric health screening in one of two ways: at a Quest Diagnostics Patient Service Center or from your doctor. If you already had a biometric health screening this year, you may be able to use those results.

Option 1: Use Quest Diagnostics. Call 1-855-623-9355 (855-6-BE-WELL) or go to my.questforhealth.com to set up your biometric health screening.

Registration Process:

Go to **My.QuestForHealth.com**
If you registered last year, you should have an account and you do not need to complete this step*, simply log in.*

1. **If you are new**, make an account. Use **CementMasons2026** as the registration key and click Register Now. Then read the terms and conditions.
2. **Click "Accept & Continue"** to go to the Confirm Eligibility page and make your account.
3. Your Unique ID (UID) is on your Anthem ID card. It starts with HA and has seven numbers. Add **E** if you are the Cement Mason Member or **S** if you are the spouse.
   Example: HA0001234**E** or HA0001234**S**.
4. Save your login information for future use.

After you finish, schedule your biometric health screening at a nearby Quest location and print your confirmation page to bring to your appointment.

Option 2: Get a biometric health screening from your doctor. Your doctor may charge a fee. You must log in to Quest (my.questforhealth.com) to print the Physician Results Form. Fill out your part, have your doctor fill out the rest, and make sure the form is faxed or uploaded to my.questforhealth.com by **December 31, 2026**.

Get ready for your biometric health screening.

FAST: Do not eat or drink anything except water for 10 to 12 hours before your appointment. Keep taking your medicine unless your doctor tells you not to. The test only takes a few minutes. They may check your blood sugar, cholesterol, triglycerides, height, weight, waist, and blood pressure. They will also ask about nicotine use.

You will get a private health report. It will explain your results and what they may mean. It is a good idea to talk about the report with your doctor.

Look at your results. After your biometric health screening, Quest Diagnostics will send you a report that you can share with your doctor.

Will anyone else see my results? No. Quest tells the Trust Fund Office only that you finished Step 2. Your personal health information stays private.

Why biometric health screenings matter

Find these risks early	Help prevent problems like
High blood pressure, high cholesterol, high blood sugar, extra weight, smoking	Diabetes, heart disease, kidney disease, stroke, some cancers

Finding health risks early can help you feel better, live healthier, and avoid bigger problems later.

Step 3: ***Get or Keep the Lower Deductible Premier Plan***

What to do for Step 3: Finish Steps 1 and 2. If you do, you will stay in or be added to the lower deductible Premier Plan starting **January 1, 2027**.

If you do not join the Promise Program and complete the steps, you will stay in the higher deductible ***Basic Plan for the entire 2027 calendar year,*** *and understand that by not participating in the 2027 calendar year, your next opportunity to participate in the Promise Program will be effective January 1, 2028.*

Important Resources

Who to call	How to reach them
Trust Fund Office	1-707-864-3300 or 1-888-245-5005 Monday through Friday, 8:00 AM to 5:00 PM Email: nccmenrollment@hsba.com
Anthem 24/7 Nurse Line	1-800-700-9184
Quest Diagnostics To schedule a screening	1-855-623-9355 (1-855-6-BE-WELL) Monday – Friday 7:00 AM – 8:30 PM CST Saturday 7:30 AM – 4:00 PM CST Website: my.questforhealth.com

The Cement Masons Health and Welfare Trust Fund for Northern California

Promise Program Election Form for Direct Payment Plan

(Complete ALL the information required in this form and return it by December 15, 2026.)

By completing this form, I choose to participate in the Promise Program and be enrolled in the lower deductible Premier Plan during the entire **2027** calendar year.

Participant Contact Information		
Name:	SSN:	DOB:
Street Address:		
City, State and Zip code:		
Email Address (if you have one):		
Home Phone No.:		
Cell Phone No. (that can accept text messages if you have one):		

Spouse Contact Information		
Name:	SSN:	DOB:
Street Address:		
City, State and Zip code:		
Email Address (if you have one):		
Home Phone No.:		
Cell Phone No. (that can accept text messages if you have one):		

❑ **Yes,** I/We agree to the terms of the Program and understand that when I/we meet the requirements, I/we will be enrolled in the Premier Plan with a $250.00 per person and $750.00 per family deductible effective January 1, 2027.

Get a biometric health screening by **December 31, 2026** from Quest Diagnostics or your doctor. Indicate the date below of your biometric health screening AFTER you have completed the screening. **DO NOT** return this form until you have completed a biometric health screening. Please read the enclosed materials for more information on scheduling a biometric health screening.

❑ **Yes**, I have completed a biometric screening on (indicate date) _____

❑ **Yes**, My spouse has completed a biometric health screening on (indicate date) _____

❑ **Yes**, I/We understand that by signing below, I/we agree to complete the Healthy Structures Promise Program Commitments as described and within the timelines noted above. **BOTH you and your spouse MUST sign and date this form; otherwise, it will be returned.**

The Cement Masons Health and Welfare Trust Fund for Northern California

By completing this form and signing below, I/We agree to the following:

- I/We, will complete a free biometric health screening by **December 31, 2026**. In doing so, we authorize the Trust Fund Office to receive notification that we completed the screening. *No individual results will be provided to the Trust Fund Office.*

- I/We, commit to take certain actions to improve my/our health and take extra steps to use the most cost-effective providers through the 24/7 Nurse Line as required by the Promise Program.

- I, will keep the Trust Fund Office up to date at all times of my contact information and that of my spouse including mailing address, email address, home and cell phone numbers by filing the necessary form on which I can update my contact information. I will call the Trust Fund Office at 1-888-245-5005 to request the necessary form. By doing so, I understand that they will be able to keep me informed with general information about the Promise Program and any other Trust Fund programs by text message, if applicable.

Participant's Signature	**Date**	**Spouse's Signature (if applicable)**	**Date**

<u>If you wish NOT to participate</u> in the Promise Program and be enrolled in the Basic Plan with $1,000.00 per person and $3,000.00 per family deductible, you do not have to do anything and understand that by not participating, your next opportunity to participate in the Program will be effective January 1, 2028.

Return this form to the Trust Fund Office by mail in the enclosed self-addressed envelope to:
Cement Masons Health and Welfare Trust Fund, 4160 Dublin Blvd Ste#100, Dublin Ca 94568

You should make a copy of this form to keep in your files. Contact the Trust Fund Office at 1-888-245-5005 if you have any questions about the Healthy Structures Promise Program. Your Trust Fund safeguards the privacy of all participants' individually identifiable health information as required by federal regulations. Unions and Employers cannot access member's individual health information.

SUMMARY ANNUAL REPORT FOR

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA

This is a summary of the annual report of the Cement Masons Health and Welfare Trust Fund, EIN 94-1291152, Plan No. 501, for period September 1, 2024 through August 31, 2025. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees of Cement Masons Health and Welfare Trust Fund for Northern California has committed itself to pay certain medical, dental, vision, prescription drug, and accidental death and dismemberment benefit claims incurred under terms of the plan.

Insurance Information

The plan has contracts with Delta Dental of California, Kaiser Foundation Health Plan Inc, The Union Labor Life Insurance Company, Anthem Medicare Preferred (PPO) and United Healthcare Insurance Company to pay medical, dental, vision, and prescription drug claims incurred under the terms of the plan. The total premiums paid for the plan year ending August 31, 2025 were $17,024,046.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $92,201,606 as of August 31, 2025, compared to $84,880,281 as of September 1, 2024. During the plan year the plan experienced an increase in its net assets of $7,321,325. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $49,424,209, including employer contributions of $42,954,842, employee contributions of $2,203,871, realized gains of $30,507 from the sale of assets, earnings from investments of $4,123,768, and other income of $111,221.

Plan expenses were $42,102,884. These expenses included $2,354,440 in administrative expenses, and $39,748,444 in benefits paid to participants and beneficiaries.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- An accountant's report;
- Financial information and information on payments to service providers;
- Assets held for investment;
- Transactions in excess of 5% of the plan assets; and
- Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Health Services & Benefit Administrators, Inc, who is the contractor administrator, at 4160 Dublin Blvd., Suite 100, Dublin, CA 94568, or by telephone at (925) 833-4335. The charge to cover copying costs will be $10.00 for the full annual report, or $0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Health Services & Benefit Administrators, Inc., at 4160 Dublin Blvd., Suite 100, Dublin, CA 94568) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SUMMARY ANNUAL REPORT FOR

CEMENT MASONS VACATION/HOLIDAY TRUST FUND FOR NORTHERN CALIFORNIA

This is a summary of the annual report of the Cement Masons Vacation/Holiday Trust Fund for Northern California, EIN 94-6108055, Plan No. 501, for period September 1, 2024 through August 31, 2025. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Board of Trustees of Cement Masons Vacation/Holiday Trust Fund for Northern California has committed itself to pay certain vacation benefit claims incurred under terms of the plan.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $4,843,867 as of August 31, 2025, compared to $4,796,424 as of September 1, 2024. During the plan year the plan experienced an increase in its net assets of $47,443. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $20,910,573, including employer contributions of $20,901,372, and earnings from investments of $9,201.

Plan expenses were $20,863,130. These expenses included $283,567 in administrative expenses, and $20,579,563 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- An accountant's report;
- Financial information and information on payments to service providers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Health Services & Benefit Administrators, Inc., who is the contract administrator, at 4160 Dublin Blvd., Suite 100, Dublin, CA 94568, or by telephone at (925) 833-4335. The charge to cover copying costs will be $3.75 for the full annual report, or $0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Health Services & Benefit Administrators, Inc at 4160 Dublin Blvd., Suite 100, D, CA 94568) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.