Cement Masons Trust Funds for Northern California

4160 Dublin Blvd. Suite 400, Dublin, CA 94568

Telephone: (707) 864-3300 • TOLL FREE (888) 245-5005 • FAX (925) 833-7301

*** ENROLLMENT PACKAGE***

EACH YEAR, CEMENT MASONS TRUST FUNDS FOR NORTHERN CALIFORNIA GIVES YOU THE OPPORTUNITY TO ELECT NEW COVERAGE. THE CHOICES AVAILABLE TO YOU ARE THE DIRECT PAYMENT PLAN (BASIC OR PREMIER) OR THE KAISER HMO PLAN (BASIC OR PREMIER).

THE DEADLINE TO ELECT DENTAL CHANGE OR ENROLL IN THE HEALTHY STRUCTURES PROGRAM IS DECEMBER 15, 2025.

THE ELECTION YOU MAKE WILL BE EFFECTIVE JANUARY 1, 2025 THROUGH DECEMBER 31, 2025.

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 Premier Delta Dental Plan,
- Vision through Vision Service Plan,
- Prescription drug coverage through Optum Rx.

You must enroll your dependents by completing an enrollment form. It is mandatory to include all dependents birthdates and social security numbers. If adding a spouse, we require a copy of the marriage certificate and if adding dependent children, we require a copy of their birth certificate. If any of your dependents are covered by another insurance, we require you to complete the Dual Coverage Questionnaire.

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

- Enrollment Form
- Dental Enrollment Form
- Healthy Structures Promise Program Election Form

  *Kaiser HSPP election form available upon request

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

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

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

If you have any questions or if you do not receive your medical, dental or prescription cards within 2 weeks after providing the enrollment documentation, please call the Fund office at the above number.

Eligibility Department

CEMENT MASONS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA
4160 Dublin Blvd, Suite 400
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 4/2023

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
4160 Dublin Blvd, Suite 400, Dublin, CA 94568
Telephone: 707 864-3300 or Toll-Free at 888-245-5005
E-Mail Address: nccmenrollment@hsba.com
Website: www.norcalcementmasons.org

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

FORMA DE SOLICITUD DE BENEFICIOS: PLANES ACTIVOS

INFORMACION DEL PARTICIPANTE (Por favor imprima claramente utilizando pluma de tinta)

NÚMERO DE SEGURO SOCIAL	PRIMER NOMBRE	MEDIO	APELLIDO

DOMICILIO RESIDENCIAL (no Apartado Postal)	CIUDAD	ESTADO	CODIGO POSTAL

NÚMERO DE TELÉFONO	**ÚNION LOCAL**	FECHA DE NACIMIENTO			GÉNERO	ESTADO CIVIL
		MES	DÍA	AÑO	☐ MASCULINO ☐ FEMININO	☐ SOLTERO/A ☐ CASADO/A

OPCIONES DEL PLAN DE BENEFICIOS DE SALUD (Usted y sus dependientes deberán inscribirse en el mismo Plan de Beneficios)

☐ **PLAN DE PAGO DIRECTO DE LOS ALBAÑILES DE CEMENTO**

☐ **KAISER PERMANENTE** SI ES AHORA O FUE ANTES MIEMBRO DE KAISER, ESCRIBA SU NÚMERO DE EXPEDIENTE MÉDICO**:** _____

INFORMACION DE DEPENDIENTE (Haga una lista de todos los dependientes que va a inscribir. Use el reverso si necesita mas espacio)

RELACIÓN	GENERO	ESCRIBA EL PRIMER NOMBRE Y INICIAL 2º NOMBRE (Y APELLIDO SI ES DIFERENTE DEL PARTICIPANTE.)	FECHA DE NAC. MES / DÍA / AÑO	NÚMERO DE SEGURO SOCIAL	SI ES AHORA O FUE ANTES MIEMBRO DE KAISER ESCRIBA SU NUMERO DE EXPEDIENTE MÉDICO
☐ CONYUGE ☐ COMPAÑERO DOMÉSTICO	☐ MASCU. ☐ FEMEN.				
NIÑO	☐ MASCU. ☐ FEMEN.				
NIÑO	☐ MASCU. ☐ FEMEN.				
NIÑO	☐ MASCU. ☐ FEMEN.				

Solicito la membresia al plan de salud. Certifico, bajo pena de perjurio, segun las leyes de California, que la informacion proporcionada en este formulario es verdadera, correcta y completa al mejor de mi conocimiento.

FECHA:_____ FIRMA DEL PARTICIPANTE:_____

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

Entiendo que (con excepción de los casos del tribunal para reclamaciones menores, las reclamaciones sujetas a los procedimientos de apelaciones de Medicare o a las regulaciones del procedimiento de reclamaciones de ERISA [Employee Retirement and Income Security Act, Ley de Seguridad de 1974 sobre los Ingresos de los Empleados Retirados] y cualquier otra reclamación que no pueda someterse a arbitraje obligatorio según las leyes vigentes) toda disputa entre mi persona, mis herederos, familiares u otras partes asociadas, por un lado y, por otro lado, Kaiser Foundation Health Plan, Inc. (KFHP), cualquier proveedor de atención médica contratado, administradores u otras partes asociadas contratados, por la supuesta violación de cualquier deber que se presente o esté relacionado con la membresía en KFHP, incluida toda reclamación por negligencia médica o del hospital (una reclamación que indica que un servicio médico era innecesario o no estaba autorizado, o bien que se prestó de forma incorrecta, negligente o incompleta), por responsabilidad civil de las instalaciones, o relativos a la cobertura o prestación de servicios o artículos, sin tomar en cuenta la teoría legal, deben decidirse a través de un arbitraje obligatorio, según la ley de California y no por medio de una demanda o recurso a un proceso judicial, excepto cuando la ley vigente indique una revisión judicial de la actuación arbitral. Acepto renunciar a nuestro derecho a un juicio con jurado y acepto el uso del arbitraje obligatorio. Entiendo que el folleto Evidencia de Cobertura incluye todas las disposiciones del arbitraje.

_____ _____

FECHA SE REQUIERE UNA FIRMA PARA EL PLAN DE KAISER PERMANENTE

SOLO PARA EL USO DE LA OFICINA DEL FONDO (Por favor no escriba en este espacio)

☐ NEW PARTICIPANT ☐ OPEN ENROLLMENT ☐ NEW DEPENDENT
☐ COBRA - DATE OF QUALIFYING EVENT_____

REMARKS:

DATE:_____BY:_____

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
CEMENT MASONS PENSION TRUST FUND FOR NORTHERN CALIFORNIA
4160 Dublin Blvd, Suite 400 Dublin, CA 94568 | Telephone: (707) 864-3300 or (888) 245-5005
E-Mail Address: nccminfo@hsba.com

BENEFICIARY ENROLLMENT FORM

BENEFICIARY INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST MIDDLE LAST

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS *(IF DIFFERENT FROM ABOVE)*	CITY	STATE	ZIP CODE

DATE OF BIRTH MONTH DAY YEAR	GENDER	HOME PHONE ☎ : / CELL PHONE :	E-MAIL ADDRESS, IF ANY
/ /	☐ MALE ☐ FEMALE		

BENEFICIARY STATEMENT

I hereby certify under penalty of perjury under the laws of the State of California that the information given in this form is true, correct and complete to the best of my knowledge.

DATE: SIGNATURE:

DEPENDENT INFORMATION - Complete this section ONLY IF YOU ARE ELIGIBLE for Health and Welfare coverage. DO NOT complete this section if you are applying for a Pension benefit only as a beneficiary.

IMPORTANT: Add "**Eligible Dependents**" or delete previously enrolled dependents below. The term "Eligible Dependents" means your children under age 26 regardless of marital status, and your unmarried children 26 years of age or older who are totally handicapped as explained in the Plan. Unless documents have been previously provided, you are required to mail the applicable document(s) below to the Fund Office to substantiate your relationship to your dependent(s). **Write your Social Security number on each of the document(s) for identification purposes.**

NATURAL – Birth Certificate **ADOPTED CHILD** – Birth Certificate and Legal adoption document
LEGAL GUARDIANSHIP – Guardianship papers or documents from a Court appointing you as the legal guardian

❗ IF ANY OF YOUR DEPENDENTS HAVE OTHER GROUP INSURANCE COVERAGE, CHECK THIS BOX ☐.

Add/Delete	Relationship	Name (First, MI, Last)	Date of Birth Month Day Year	Social Security No.
☐ Add ☐ Delete	☐ Son ☐ Daughter		/ /	- -
☐ Add ☐ Delete	☐ Son ☐ Daughter		/ /	- -
☐ Add ☐ Delete	☐ Son ☐ Daughter		/ /	- -

❗ **· You will be responsible for any incorrectly paid claims resulting from your failure to notify the Fund Office of changes in dependent status, such as, but not limited to, death, divorce, or loss of legal guardianship.**
· This form will be returned if you fail to provide the dependent's date of birth and Social Security number.

FUND OFFICE USE ONLY

DECEASED PENSIONER'S SSN	NAME

Cement Masons Health & Welfare Trust Fund for Northern California

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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

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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: _____

---

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: _____

CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
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Dublin, CA 94568
Telephone: (707) 864-3300 or (888) 245-5005
E-Mail Address: nccminfo@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:_____

Revised 4/2023

The Healthy Structures Promise Focus on Health

The Healthy Structures Promise is based on the idea that when you know more about your health status and understand potential health risks, you'll be able to improve or maintain your health.

The Healthy Together Partnership
We are all in this together.

When you and your spouse, if any, have read and have agreed to the Promise by signing and dating the Promise Form, you both have committed to:

1. Get a free biometric health screening by December 15, 2024
2. Keep your contact information up to date.
3. Provide an email address and/or cell phone number as a supplemental way for the Trust Fund Office to contact you with general information about the Promise Program and other Trust Fund Programs.
4. Call our Care Counseling service before you receive outpatient care. Care Counselors and the Nurse Line are available at 1-855-754-7271

When you and your spouse have agreed to the Promise, we agree to:

1. Provide you with a free biometric health screening.
2. Connect you with resources to help you understand what the results mean and what steps to take to improve your health.
3. Enroll you in the lower deductible Premier Plan

With the right resources and tools, you can better understand your health status, know your health risks, and make smart choices about your lifestyle and care. That is the goal of the Healthy Structures Promise Program. We all have a stake in being healthy.

Step 1: Complete the Promise Form

After you and your spouse have read the Promise Form, and if you agree to carry out the commitments outlined in the Promise Program, you need to:

1. Complete the form.
2. Sign and date the form.
3. Return your completed form to the Trust Fund Office no later than **December 15, 2024** in the enclosed self-addressed envelope.

You and your spouse are both making a commitment to your health. The Promise Program is completely voluntary, and it is your decision to participate. If you do not wish to participate or renew participation in the Promise Program, you will remain or be enrolled in the Basic Plan with the higher annual deductible as described in Step 3 on page 3.

Promise to Stay Connected. Keeping you informed of important messages is part of our role in the Promise Program. That is why we need to have current contact information and an additional way to communicate with you and your spouse. So, as part of the Promise Program, we are asking you to provide an email address and/or cell phone number that accept text messages, if you have one.

Moving? New phone number? New email address? Part of the Promise Program involves keeping the Trust Fund Office updated with your contact information. Any time there is a change to your home address, phone number, email and/or cell phone number, call the Trust Fund Office at 1-888-245-5005 to request the form on which can update your information**. If you do not keep your contact information updated, it may cause you to lose your enrollment in the Premier Plan.**

Step 2: Get a Free Biometric Health Screening

As part of the Promise Program, you and your spouse must take a **free biometric health screening by December 15, 2024**

This screening will help identify any potential health risk factors you or your spouse may have that can lead to chronic illness if not detected early. Knowing this information and then working with your doctor to improve your health can help you live a healthier and more productive life. The biometric health screening is explained on page 3.

Here's what to do for Step 2: Scheduling Your Biometric Screening
The process for scheduling a biometric health screening is explained below. Note: You must be eligible for benefits in the month you schedule and receive your biometric health screening. To confirm eligibility, call the Trust Fund Office at 1-888-245-5005. If you are a Kaiser Permanente member who wants to switch to the Direct Payment Plan, you must contact the Trust Fund Office first in order to complete Quest's online Registration Process as described below.

You can get your biometric health screening through Quest Diagnostics® Patient Service Center (PSC) or through your doctor — see **Option 1** and **Option 2** below. You may use biometric health screening results obtained this year (2023) if you have previously received a screening.

Option 1: To schedule a Blueprint for Wellness@ biometric health screening with Quest Diagnostics, call 1-855-623-9355 (855-6-BE-WELL) or go online at my.questforhealth.com. There is a video tutorial of participant registration at: https://youtu.be/r8ZPsPyB-7A

REGISTRATION PROCESS: Go to http://My.QuestForHealth.com web site. When you are on my.questforhealth.com home page, you will need to either Login if you already have a user account or to create a new user account. If you are a new user, you must enter: **CementMasons2024** in the REGISTRATION KEY box, then click the Register Now button where you will be taken to the Terms and Conditions page. After reading the terms and conditions you will click on “Accept & Continue” which will take you to the “Confirm Eligibility" page to create a user account. Your Unique ID (UID) is your ID number on your Anthem Identification card starting with HA, then seven numbers, plus the letter E if you are the Cement Mason or the letter S for your spouse, if any. For example, using the sample ID card at the right, enter HA0001234E as your UID; enter HA0001234S as your spouse's UID. Enter the rest of the information required to complete the registration process. Follow the steps after the registration page to schedule your screening at a nearby Quest Diagnostics PSC. **Be sure to print your confirmation page when you are finished and take it with you to your appointment.**
Option 2: Obtain a biometric health screening from your doctor. Be aware that your doctor may charge you a fee if you take this option. If you choose this option, you and your doctor must complete a Physician Results Form which can be obtained and printed only by signing into your user account with Quest — this is for security reasons as the form is bar coded with your UID. First, follow the REGISTRATION PROCESS as described above. After logging in or registering, several screens will appear. Click the following tabs as they appear: "Get Started", "Participate Now" and "Select" Physician Results Form. Complete your part then bring the form to your doctor and have your doctor fill out his part. The completed form must be faxed back by your doctor to Quest Diagnostics at the fax number shown on the form or uploaded to my.questforhealth.com by **December 15, 2024**.

Review your results. After you complete your screening, you will receive the Quest Diagnostics Blueprint for Wellness My Test Profile report to share with your doctor.

Will my personal results be shared? No. Quest Diagnostic will notify the Trust Fund Office that you successfully completed Step 2 of the Promise Program by getting a biometric health screening. Your personal health information is confidential and will never be shared with anyone other than you. The Trust Fund Office will only know that you and your eligible spouse, if any, completed Step 2 so that you will be eligible for the lower deductible Premier Plan.

Prepare for your biometric health screening. To prepare for your screening, it's important to not eat or drink anything, other than water, for 10 to 12 hours before your appointment. The most accurate blood test results are obtained when you are "fasting." Take all medication as prescribed by your physician. The typical biometric health screening test takes only a few minutes. When you go to your appointment, the health professional will draw a small blood sample that will be used to measure: Glucose (or level of sugar in your blood) *Cholesterol (good, bad and total) *Triglycerides (the types of fats in your blood). The health professional will also measure your: Height / Weight / Waist / Blood pressure.

And finally, your health professional will ask you about your use of nicotine.

You will receive a confidential, detailed health report after your biometric health screening. After your screening, you will receive a confidential health report. The report will explain your results, health risks and suggest actions you can take to improve your health. It is a good idea to make an appointment with your primary doctor to go over your results. Your doctor can help you understand what your results mean and help you plan your next steps to improve your health.

Why biometric health screenings are important:

If you know these risks early:	You can prevent illness such as:
high blood pressure, high cholesterol high glucose, overweight, smoking	Cancer, diabetes, heart disease, kidney disease, stroke

Identifying potential health risks now through a biometric health screening—and treating them early— can help you feel better, live longer and keep certain conditions from becoming more severe and, as a result, costlier to treat.

Step 3: Receive or Remain in the Lower Deductible Premier Plan

Here's what to do for Step 3: Make sure you complete Steps 1 and 2 by December 15, **2024**. When you complete Steps 1 and 2 of the Healthy Structures Promise by December 15, **2024**. you will remain or be enrolled in the lower deductible Premier Plan effective January 1, **2025**.

If you decide not to participate in the Promise Program and follow through with the commitments, you will remain in the higher deductible ***Basic Plan for the entire*** **2025** ***calendar year.***

Open Enrollment: In order to remain enrolled in the Premier Plan, you will be required to renew your Promise, complete a Promise Form **and** have a biometric screening annually which begins every October. If you have decided not to participate in the Promise Program at this time, you will have an opportunity again during the next open enrollment.

Important Resources

Resources	Contact Information
Cement Masons Health and Welfare Trust Fund	1-707-864-3300 or Toll Free 1-888-245-5005 Monday through Friday 8:00 AM to 5:00PM Email: nccmenrollment@hsba.com
Pacific Health Alliance – Care Counseling	1-855-754-7271
Quest Diagnostics Blueprint for Wellness To schedule a biometric health screening appointment	1-855-623-9355 (1-855-6-BE-WELL) Customer Support Hours (Central Standard Time) Monday – Friday 7:00 AM – 8:30 PM Saturday 7:30AM – 4:00 PM 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 31, 2024.**)

Our record indicates that you are either currently enrolled in the higher deductible Basic Plan or enrolled in the lower deductible Premier Plan and must renew your participation in the Promise Program. Your annual opportunity to participate in the Healthy Structures Promise Program and enroll in the lower deductible Premier Plan for the coming **January-December 2024** 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, 2025.** If you choose not to participate in the Promise Program, you will be enrolled in the higher deductible Basic Plan during the entire 2025. calendar year. We hope that you will participate and commit to take certain actions to improve your health and take extra steps to use the most cost-effective providers through the Care Counseling service as required by the Promise Program. By participating, we believe that your decision will save you and the Trust Fund thousands of dollars.

Healthy Structures Promise Program Commitments

To participate in the Promise Program, you and your spouse agree to take the following actions:

1. I, and my spouse will complete a free biometric health screening by December 31, 2024. 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.

2. 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. Please complete the **following information.**

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