

# Cement Masons & Plasterers Trust Funds

2815 2<sup>nd</sup> Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124  
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website  
www.cementmasonstrust.com

Administered by  
Welfare & Pension Administration Service, Inc.

March 2, 2016

**TO: All Active and Retired Participants  
Cement Masons and Plasterers Health and Welfare Plan**

**RE: Changes to your Vision and Dental Benefits  
Annual Open Enrollment for Dental Coverage  
Summary of Benefits and Coverage**

*This is a Summary of Material Modification describing changes adopted by the Board of Trustees. Please be sure that you and your family read this information carefully and keep it with your Plan Booklet.*

## **CHANGES TO VISION BENEFITS**

**Maximum Benefits for Children Under Age 18 (refer to pages 90-93 of the April 2013 Plan Booklet):** Effective April 1, 2016, the benefits payable under the self-insured Scheduled Vision Benefit Plan for dependents under age 18 will be limited to the scheduled amounts in the Plan Booklet without coinsurance. The scheduled amounts will also continue to apply to all other Covered Persons.

The benefits provided through National Vision, Inc. have not changed, and that continues to be an alternative to the self-insured Scheduled Vision Benefit Plan. National Vision, Inc. providers have agreed to discounted rates for vision care services, which limits your out-of-pocket expenses.

**No Out-of-Pocket Limit:** Your out-of-pocket expenses for vision services, including coinsurance and copayments, are not included in calculating your annual out-of-pocket limit.

**Vision Benefit Opt-Out:** In order that vision benefits can be considered excepted from the Patient Protection and Affordable Care Act, the Trust must give you the option to opt out. Electing to opt out of vision benefits will not change your dollar bank deduction rate. If you nonetheless want to opt out, please send a written request to the Administration Office at the address indicated above.

## CHANGES TO DENTAL BENEFITS

Changes have been made to both the Traditional (self-insured) Dental Plan and the Willamette Dental Plan effective **April 1, 2016**. Please review these changes carefully, and keep them in mind if you are considering a change in the selection of your dental care program during the dental coverage annual open enrollment period, described below.

### Traditional (self-insured) Dental Plan (refer to pages 81-88 of the April 2013 Plan Booklet)

**Annual Deductible:** All Covered Persons must satisfy a calendar year deductible for Allowable Charges before any dental benefits are provided. The calendar year deductible will increase from \$25 per person per calendar year **to \$50** per person per calendar year for services incurred on April 1, 2016 and thereafter. Amounts you have already satisfied between January 1, 2016 and March 31, 2016 will be carried forward and applied towards satisfying the new \$50 deductible. The deductible is waived for Preventive Services (Class A),

**Annual Maximum Benefits for Children Under Age 18:** The \$2,000 dental annual maximum will apply to children under age 18 effective for services on and after April 1, 2016. The annual maximum will also continue to apply to all other Covered Persons.

**No Out-of-Pocket Limit:** Your out-of-pocket expenses for dental services, including the deductible, coinsurance and copayments, are not included in calculating your annual out-of-pocket limit.

### Willamette Dental (refer to page 88 of the April 2013 Plan Booklet)

Effective with claims incurred on or after April 1, 2016, certain copayments under the Willamette Dental program will be added or changed, as follows:

<u>Service</u>	<u>Current Copayments</u>	<u>Copayments Effective April 1, 2016</u>
Root Canals (per root)	\$50/\$75/\$100	\$50/\$100/\$175
Surgical Extractions	No copayment	\$75 copayment
Root Planing	No copayment	\$50 copayment

## DENTAL COVERAGE OPEN ENROLLMENT DEADLINE IS MARCH 21, 2016

**Annual Open Enrollment for Dental Coverage:** The annual open enrollment to change your family's dental coverage is being held through **March 21, 2016**, for a coverage effective date of April 1, 2016. During open enrollment, you have the opportunity to choose **either** the Traditional Dental Plan offered by the Trust **or** the Willamette Dental program.

If you are satisfied with your current dental plan and don't wish to make a change, **no action is required**.

Once enrolled in either the Trust's Traditional Dental Plan or Willamette Dental program, **you are required to remain on that plan until the next open enrollment period in 2017**. Dependent coverage must mirror the participant's election, so your dependents will be covered under the same plan you elect for yourself.

**How to Compare the Plans:** Enclosed are the Summary of Benefits for both the Trust's Traditional Dental Plan and the Willamette Dental program. You should evaluate the difference in out-of-pocket costs between the two plans. Those costs include copayments, coinsurance, annual benefit maximums, and services covered. Most services covered by the Trust's Traditional Dental Plan are subject to coinsurance based on your or your family member's individual incentive level. When covered by the Trust's Traditional Dental Plan, you can obtain services from the dentist of your choice. If you elect coverage through Willamette Dental you must obtain all treatment at Willamette Dental offices. **With the exception of out-of-area emergency care, if you elect the Willamette Dental program, any care that is not received at a Willamette Dental office will not be covered.**

**Only participants who wish to make a change to their current dental plan are required to return the enclosed Dental Plan Election Form.** If we do not receive an election form from you, your benefits will continue to be provided based on the most recent dental coverage election the Administration Office has on file for you and your family. A change in dental enrollment will not affect your other health and welfare benefits provided by the Trust.

**Dental Benefit Opt-Out:** In order that the Traditional Dental Plan can be considered excepted from the Patient Protection and Affordable Care Act, the Trust must give you the option to opt out. Electing to opt out of dental benefits will not change your dollar bank deduction rate. If you nonetheless want to opt out of all dental benefits, please send a written request to the Administration Office at the address indicated above.

### **THE DEADLINE TO CHANGE YOUR DENTAL COVERAGE IS MARCH 21, 2016**

For questions regarding the Traditional Dental Plan benefits, you may refer to your April 2013 edition of the Plan booklet (and summaries of material modification) or contact the Administration Office at (206) 441-7574 or (800) 331-6158, option 0.

For question regarding the Willamette Dental program, you may contact Willamette Dental Member Services at (855) 433-6825, option 3 or visit the Willamette Dental website at [www.WillametteDental.com](http://www.WillametteDental.com).

If you are an active member and have any questions regarding the open enrollment, please contact the Administration Office's Eligibility Department at (800) 732-1121, option 4. If you are a Retiree, contact Dena at (800) 732-1121 ext. 3309.

### **SUMMARY OF BENEFITS AND COVERAGE**

In accordance with the Patient Protection and Affordable Care Act as amended, the Trust is required to provide a **Summary of Benefits and Coverage** (SBC) to all participants and beneficiaries. The SBC illustrates the benefits currently provided to you by the Plan for Medical, Prescription Drug, traditional Dental and Vision care. You will find this document enclosed. *Please note, the SBC furnished to the participant will be considered provided to dependents unless the Plan has been advised of a different address for dependents.*

The SBC is intended to help you better understand the coverage currently available to you and what the Plan covers and what it costs. The SBC also includes details, called "coverage examples," which allow you to see what the plan might cover in two common medical situations, see page 7 of the SBC. If you are eligible or enrolled in Medicare or have primary coverage through another group health plan, this plan's benefits will be coordinated with that other plan and differ from what's indicated in the SBC, and the coverage examples. It is important to note that the SBC is only a **summary** and does not replace the Summary Plan Description (plan booklet). **The SBC is not intended to be a cost estimator and should not be used to estimate your actual costs.**

A **Uniform Glossary of Terms** has also been published by the government. This document is intended to describe terms commonly used in health insurance coverage, such as "deductible" and "copayment". Both the SBC and the Uniform Glossary of Terms have been posted to the Trust's website at [www.cementmasonstrust.com](http://www.cementmasonstrust.com) or to obtain a copy call the Administration Office at (800) 331-6158, option 0.

If you have any questions regarding the information outlined in this notice, please contact the Administration Office at (206) 441-7574 or (800) 331-6158, option 0.

**Board of Trustees**  
**Cement Masons and Plasterers Health and Welfare Plan**

C:\mm opeiu#8  
S:\Mailings\Open Enrollment\F16\F16-02 - 2016 - Dental Open Enrollment Notice - 03.001.2016.doc

Enclosure

## Cement Masons and Plasterers Health and Welfare Plan

The Traditional Dental Care Plan provides coverage for both Class A and B services, called “Preventive and Routine Services,” and Class C services, called “Major Services.” Retired Participants and their dependents are covered only if dental care coverage was selected at the time of enrollment for Retiree benefits. When electing coverage through the Traditional Dental Care Plan, you may use a dental provider of your choice.

<b>Traditional Dental Plan Summary</b>											
<b>Calendar Year Deductible</b>	<b>\$50</b> per person Waived for Class A Preventive Services										
<b>Calendar Year Maximum</b>	<b>\$2,000</b> per person										
<b>Co-payment Percentage</b>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="text-align: right; width: 40%;"><b>Percentage Payable</b></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><b>Preventive and Routine</b> (Class A &amp; B Services)</td> <td style="text-align: right;">First Year 70%*</td> </tr> <tr> <td></td> <td style="text-align: right;">Second Year 80%*</td> </tr> <tr> <td></td> <td style="text-align: right;">Third Year 90%*</td> </tr> <tr> <td></td> <td style="text-align: right;">Fourth Year 100%*</td> </tr> </tbody> </table> <p>You must have a dental treatment each year in order to move to the next higher percentage level. If you do not have dental treatment in any one year, your percentage level will drop back 10%, but in no event will it be less than 70%.</p> <p style="text-align: center;"><b>Major Services</b> (Class C Services) 50%*</p> <p><i>*of Allowable Charges</i></p>		<b>Percentage Payable</b>	<b>Preventive and Routine</b> (Class A & B Services)	First Year 70%*		Second Year 80%*		Third Year 90%*		Fourth Year 100%*
	<b>Percentage Payable</b>										
<b>Preventive and Routine</b> (Class A & B Services)	First Year 70%*										
	Second Year 80%*										
	Third Year 90%*										
	Fourth Year 100%*										
<b>Treatment of Temporomandibular Joint Disease or Disorder</b>	\$750 per person cumulative lifetime benefit										
<b>Description of Class A, B and C Services</b>											
<i>This is only a summary of covered dental services. For a complete list of covered services, limitations and exclusions, refer to your Summary Plan Description (plan booklet).</i>											
<b>Preventive and Routine Services – Class A &amp; B</b>	<ul style="list-style-type: none"> <li>• Oral Exams (limited to 2 per year)</li> <li>• Dental X-rays (full mouth or panoramic X-rays once ea 3 cal years)</li> <li>• Cleanings (limited to 2 per year)</li> <li>• Dental Sealants (for dependents under age 16)</li> <li>• Extractions</li> <li>• Fillings</li> </ul>										
<b>Major Services Class C</b>	<ul style="list-style-type: none"> <li>• Bridges</li> <li>• Crowns</li> <li>• Dentures</li> </ul>										
<b>Orthodontia</b>	Not Covered										

# Summary of Benefits

Group Number: WA34  
Effective Date: 4/1/2016



## Cement Masons and Plasterers

COPAYS	
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General Office Visit	You pay \$20 per Visit
DIAGNOSTIC AND PREVENTIVE SERVICES	
Routine and Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY	
Fillings (Amalgam)	Covered with the Office Visit Copay
Porcelain-Metal Crown	You pay a \$100 Copay
PROSTHODONTICS	
Complete Upper or Lower Denture	You pay a \$250 Copay
Bridge (per Tooth)	You pay a \$100 Copay
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – Anterior	You pay a \$50 Copay
Root Canal Therapy – Bicuspid	You pay a \$100 Copay
Root Canal Therapy – Molar	You pay a \$175 Copay
Osseous Surgery (per Quadrant)	You pay a \$150 Copay
Root Planing (per Quadrant)	You pay a \$50 Copay
ORAL SURGERY	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	You pay a \$75 Copay
ORTHODONTIA TREATMENT	
Pre-Orthodontia Treatment	You pay a \$150 Copay**
Comprehensive Orthodontia Treatment	You pay a \$2,000 Copay
MISCELLANEOUS	
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a \$40 Copay
Specialty Office Visit	You pay a \$30 Copay per visit
Out of Area Emergency Care Reimbursement	You pay charges in excess of \$100

\*TMJ has a \$1000 annual maximum/ \$5000 lifetime maximum

\*\*Copayment credited towards the Comprehensive Orthodontic Service copayment if patient accepts treatment plan.

### Underwritten by Willamette Dental of Washington, Inc.

This plan provides extensive coverage of services and supplies to prevent, diagnose, and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

# Exclusions and Limitations

## Exclusions

Bridges, crowns, dentures or any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.

The completion or delivery of treatments, services, or supplies initiated prior to the effective date of coverage

Dental implants, including attachment devices and their maintenance.

Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.

Endodontic therapy completed more than 60 days after termination of coverage.

Exams or consultations needed solely in connection with a service or supply not listed as covered.

Experimental or investigational services or supplies and related exams or consultations.

Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of splinting, altering vertical dimension, restoring occlusions or correcting attrition, abrasion, or erosion.

Hospital care or other care outside of a dental office for dental procedures, physician services, or facility fees.

Maxillofacial prosthetic services.

Nightguards.

Personalized restorations.

Plastic, reconstructive, or cosmetic surgery and other services or supplies, which are primarily intended to improve, alter, or enhance appearance.

Prescription and over-the-counter drugs and pre-medications.

Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.

Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.

Replacement of sound restorations.

Services or supplies and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Willamette Dental Group dentist.

Services or supplies and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.

Services or supplies by any person other than a licensed dentist, denturist, hygienist, or dental assistant.

Services or supplies for treatment of injuries sustained while practicing for or competing in a professional athletic contest.

Services or supplies for the treatment of an occupational injury or disease, including an injury or disease arising out

of self-employment or for which benefits are available under workers' compensation or similar law.

Services or supplies for treatment of intentionally self-inflicted injuries.

Services or supplies for which coverage is available under any federal, state, or other governmental program, unless required by law.

Services or supplies not listed as covered in the contract.

Services or supplies where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

## Limitations

If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.

Services or supplies listed in the contract, which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures will be covered for dependent children if dental necessity has been established.

Orthognathic surgery is covered as specified in the contract when the Willamette Dental Group dentist determines it is dentally necessary and authorizes the orthognathic surgery for treatment of an enrollee, under age 19, with congenital or developmental malformations.

Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.

When initial root canal therapy was performed by a Willamette Dental Group dentist, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. When the initial root canal therapy was performed by a non-participating provider, the retreatment of such root canal therapy by a Willamette Dental Group dentist will be subject to the applicable copayments.

General anesthesia is covered with the copayments specified in the contract if it is performed in a dental office; provided in conjunction with a covered service; and dentally necessary because the enrollee is under the age of 7, developmentally disabled or physically handicapped.

The services provided by a dentist in a hospital setting are covered if medically necessary; pre-authorized in writing by a Willamette Dental Group dentist; the services provided are the same services that would be provided in a dental office; and applicable copayments are paid.

The replacement of an existing denture, crown, inlay, onlay, or other prosthetic appliance or restoration denture is covered if the appliance is more than 5 years old and replacement is dentally necessary.