Northern California Tile Industry Trust Funds

Health & Welfare • Vacation & Holiday • Defined Benefit Pension • Defined Contribution Pension

June 2026

MEMORANDUM TO: All Active Participants
Northern California Tile Industry
Health & Welfare Trust Fund

FROM: Administration Office

SUBJECT: OPEN ENROLLMENT – 2026
REMINDER REGARDING BENEFICIARY DESIGNATION

The Trust's open enrollment period for 2026 has begun. From now until June 30, 2026, you will have the opportunity to change your medical plan if you wish. Please see the enclosed Open Enrollment Change Form for details and conditions.

The Trust currently offers two medical plans: the Self-Funded PPO, and Kaiser HMO. A comparison of these plans is enclosed in this packet, and available at www.bac3tilebenefits.org /Documents/Health Care/Summary of Benefits and Coverages, the dedicated website for the Northern California Tile Industry Trust Funds.

A copy of the Open Enrollment Change Form can also be found at www.bac3tilebenefits.org, along with many other useful forms and information about your plans.

We also strongly encourage all participants to complete and submit their Beneficiary Designation Form as soon as possible. A copy of the Updated Beneficiary Designation Form is included. Please complete the form and send to the address below. You may also contact our office if you are not sure if you have previously submitted a valid Beneficiary Designation Form.

If you are an active participant and haven't utilized the log-in feature of the site, we highly recommend that you do so. Setting up a secure, encrypted account is easy and takes less than a minute. Once an account has been established, active participants can access personal information, including hours reported.

If you have any questions, please contact the eligibility department at (888) 208-0250.

7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566
P.O. Box 1607 San Ramon, CA 94583
Phone 925.208.9995 • Toll Free 888.208.0250 • Facsimile 925.462-0108
www.bac3tilebenefits.org • staff@bac3tilebenefits.org

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OPEN ENROLLMENT FORM

Date of Hire: _____
Event Date: _____
Effective Date: _____

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME:_____ SSN: _____

ADDRESS:_____ CITY: _____

STATE:_____ ZIP:_____ DATE OF BIRTH:_____ GENDER: (Circle One) Male Female

EMAIL:_____ PHONE NUMBER: (_____) _____

MEDICAL PLAN (CHOOSE ONE):	**DENTAL:**
☐ SELF-FUNDED PPO PLAN (INDEMNITY PLAN)	SELF-FUNDED PPO PLAN
☐ KAISER (PID#376)	**VISION:**
****If enrolling in Kaiser, you must also sign the Arbitration Agreement below****	VISION SERVICE PLAN

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:
Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

FULL NAME	SOCIAL SECURITY #	DATE OF BIRTH	GENDER	RELATIONSHIP

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.

_____ _____
Signature Required to Enroll in Kaiser Permanente Plan **Date**

I agree to notify the Trust Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of defrauding obtaining plan coverage. Penalties may include imprisonment, fines, and denial of benefits.

MEMBER SIGNATURE_____**DATE:** _____

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Beneficiary Election Form

Participant Name_____ **SSN**_____ **DOB** _____

Address _____

(if applicable) **Spouse Name** _____ **SSN**_____ **DOB** _____

(if applicable) **Domestic Partner Name** _____ **SSN**_____ **DOB** _____

Below please indicate the person(s) you wish to name as beneficiary(ies) of any death benefits for the:

- Northern California Tile Industry Defined Benefit Plan ("Defined Benefit Plan"),
- Northern California Tile Industry Defined Contribution Plan ("Defined Contribution Plan"),
- Northern California Tile Industry Vacation and Holiday Plan ("Vacation Plan") and/or
- Life Insurance Benefits under the Northern California Tile Industry Health and Welfare Plan ("Health and Welfare Plan").

Note Regarding Spousal Consent for Defined Benefit Plan and Defined Contribution Plan only:
If you are legally married at the time of your death Federal law and the Defined Benefit Plan and the Defined Contribution Plan require that benefits be paid to your surviving spouse, unless your spouse consents to the payment of the benefit to someone else.

If you elect below to designate someone other than your spouse as your Primary Beneficiary for the Defined Benefit Plan and Defined Contribution Plan – your spouse will have to complete the Spousal Consent of Beneficiary Designation Section on page 3 by providing a notarized statement consenting to your Primary Beneficiary designation.

Primary Beneficiary Designation

This designation is for (*please check applicable box(es)):*

- ☐ All Plans
- ☐ Defined Benefit Plan only
- ☐ Defined Contribution Plan only
- ☐ Health and Welfare Plan (Life Insurance Benefits) only
- ☐ Vacation Plan only

If you would like to designate multiple Primary beneficiaries, please attach an additional page with the information below for each Primary beneficiary and for each plan selected by checking the box(es). .

Primary Beneficiary_____ **SSN**_____ **DOB** _____

Address_____ **Relationship**_____

Phone Number_____ **Percentage of benefit* (see details below)**_____

See next page for Contingent Beneficiary Designation and Participant Signature

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Contingent Beneficiary Designation

This designation is for (*please check applicable box(es)*):

- ☐ All Plans
- ☐ Defined Benefit Plan only
- ☐ Defined Contribution Plan only
- ☐ Health and Welfare Plan (Life Insurance Benefits) only
- ☐ Vacation Plan only

Contingent beneficiary(ies) would receive benefits ONLY if there is no Primary beneficiary(ies) living at the time death benefits become payable. If you would like to designate multiple Contingent beneficiaries, please attach additional pages with the information below for each Contingent beneficiary and for each plan selected by checking the box(es).

Contingent Beneficiary_____ **SSN**_____ **DOB** _____

Address_____ **Relationship**_____

Percentage of benefit _____

---

* **Note regarding Percentage of Benefit:** If you designate more than one Primary Beneficiary, benefits will be paid to them in equal shares, unless you fill in a different percentage to be received where indicated on this form. For example, if you name two Primary Beneficiaries you may state that one will receive 75% and the other 25%. Benefits will be paid to the person you list as a Contingent Beneficiary only in the event your Primary Beneficiary(ies) have died. If you fail to designate a Beneficiary or if all of your designated Beneficiaries have died, the benefits will be paid in accordance with Plan rules.

Note regarding Dissolution of Marriage/Dissolution of Domestic Partnership: Any designation of your spouse or domestic partner as your designated beneficiary will be automatically revoked upon the dissolution of your marriage/domestic partnership. We recommend updating this designated beneficiary form after such an event occurs.

Note regarding Defined Benefit Plan Death Benefit and Beneficiary Designation: This beneficiary designation form for the Defined Benefit Plan is only applicable to participants who have already retired under a Single Life Annuity with 60 months guarantee and have designated a beneficiary at the time of retirement, and you want to change your designated beneficiary now, in which case the beneficiary designated on this form will be paid any remaining monthly benefits. If you die prior to retirement, then any Pre-Retirement Survivor Annuity or Pre-Retirement Death Benefit must be paid to your surviving spouse/domestic partner, or if none, to your children, regardless of any Defined Benefit beneficiary designation on this form.

Participant Signature

I understand that this beneficiary designation cancels any previous designation I may have made and will be effective when received in the Fund office and only if received prior to my death. Further, I understand that any designation for the Defined Benefit Plan, Defined Contribution Plan, Vacation Plan and Health and Welfare Plan shall be cancelled if my current marriage/domestic partnership ends and I remarry/enter into a new registered domestic partnership, which would make my legal spouse/domestic partner at the time of my death my new Primary Beneficiary.

Participant Signature _____ **Date** _____

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SPOUSAL CONSENT OF BENEFICIARY DESIGNATION
FOR DEFINED BENEFIT PLAN AND DEFINED CONTRIBUTION PLAN ONLY

I hereby consent to the designation of the beneficiary on this Designation of Beneficiary form for the Defined Benefit Plan and Defined Contribution Plan and understand that any benefits due as a result of my Spouse's death will be paid to the named beneficiary(ies).

Signature of Spouse **(Must be notarized)**: _____

Date: _____

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of _____)

On _____ before me, _____

Personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

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Coordination of Benefits

Member's Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____

☐ ***If you and/or spouse/dependents DO NOT have any other insurance coverage, please check this box turn over and sign/date the bottom of the next page (under "Member Statement").***

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

A

MEMBER HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical Carrier: _____ Policyholder name: _____ Policy Number: _____

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

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

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

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

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

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

B

SPOUSE AND DEPENDENTS HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical Carrier: _____ Policyholder name: _____ Policy Number: _____

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

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

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

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

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

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

1.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

2.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

Continuation on other Side

For additional dependents, ATTACH A SEPARATE sheet with employee's name at top. (Last, First, MI)

3.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

4.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

C

FILL OUT THIS SECTION ONLY IF YOUR CHILD(REN) HAVE ADDITIONAL HEALTHCARE COVERAGE DUE TO •DIVORCE •SEPARATION •COURT ORDER •MEDICARE OR •OTHER FEDERAL-STATE HEALTH INSURANCE PROGRAMS.

*****(Indicate which child by marking appropriate circle) *****

1.) Is child(ren) covered by Medicare or other Federal-State coverage? □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Medicare: Policyholder name: _____ Policy Number: _____
Is coverage because of? □ Age □ Disability □ ESRD
Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

Medi-Cal/Medicaid: Policyholder name: _____ Policy Number: _____

2.) Does one parent/guardian have full custody of the child(ren): □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

3.) Is one parent required by court decree to provide health insurance for child(ren): □ Yes or □ No ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

Name of person responsible for child's healthcare coverage? _____
Employer: _____ Date of Birth: _____
Insurance Company name: _____ Insurance Company City & State: _____
Insurance Company Phone Number: _____ Enrollee ID/ policy number: _____
Group Number: _____ Effective date: _____ Cancellation date (if applicable): _____

******If court decree is present please PROVIDE A COPY of the court documents ******

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I am also aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers because of such material in any matter.

Signature: _____ **Phone #:** _____ **Date:** _____

KAISER PERMANENTE®: TRADITIONAL PLAN **Coverage for: Individual/Family | Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual / $3,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 / visit	Not Covered	None
	Specialist visit	$35 / visit	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	$50 / procedure	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	$10 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs (Tier 2)	$25 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines.
	Non-preferred brand drugs (Tier 2)	$25 / prescription	Not Covered	The cost sharing for non-preferred brand drugs under this plan aligns with the cost sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	$25 / prescription	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	None
	Emergency medical transportation	$50 / trip	$50 / trip	None
	Urgent care	$35 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: $35 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 / individual visit. No Charge for other outpatient services	Not Covered	Mental / Behavioral Health: $17 / group visit; Substance Abuse: $5 / group visit.
	Inpatient services	$250 / admission	Not Covered	None
If you are pregnant	Office visits	No Charge	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	Professional services are included in the Facility services.
	Childbirth/delivery facility services	$250 / admission	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient: $250 / admission; Outpatient: $35 / visit	Not Covered	None
	Habilitation services	$35 / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	100 day limit / benefit period.
	Durable medical equipment	No Charge	Not Covered	Requires prior authorization.
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Chiropractic care
- Cosmetic surgery
- Dental Care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (plan provider referred)
- Bariatric surgery
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.dmhc.ca.gov

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

TRADITIONAL CHINESE (Et 文): 如果需要 Et 文 AJ 帮 UM,请拨 1T 这个号码 1-800-757-7585 (TTY: 711)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-278-3296 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-278-3296 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, á'gang 1-800-278-3296 (TTY: 711)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$250
Other (blood work)	$10

This EXAMPLE event includes services like: Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*) Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$350**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$250
Other (blood work)	$10

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall	$0
Specialist copayment	$35
Hospital (facility) copayment	$250
Other (x-ray) copayment	$10

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.

- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)
- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Office of Civil Rights
  Department of Health Care Services
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  California Department of Health Care Services Office of Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office of Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html

- **Online:** Visit the **Office of Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see **www.bac3tilebenefits.org** or by calling **1-888-208-0250**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary or call 1-888-208-0250 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For **PPO providers**: **$250** person/**$750** family (up to three individuals) For **non-PPO providers**: **$500** person/**$1,500** family (up to three individuals)	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible.**
Are there services covered before you meet your deductible?	Yes. **Preventive care**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/. For a list of covered immunizations, please see https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/publichealth4all/vaccines.aspx
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	For **PPO providers**, **$1,250** person/**$3,750** family. For **non-PPO providers**, **$8,500** person/ **$25,500** family.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billed** charges, health care this **plan** doesn't cover, and drug **copays** for a brand name drug when a generic is available	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes, see www.blueshieldca.com/NetworkPPO **or** 1-888-208-0250 for a list of **network providers**	This **plan** uses a **provider network.** You will pay less if you use a **provider** in the **plan's network.** You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use **an out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

- All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
If you visit a health care provider's office or clinic or telehealth office visit	Primary care visit to treat an injury or illness	$10 **copayment** / visit	$20 **copayment** / visit	Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to $10 **copayment**/visit, unless you consent to the non-PPO billing rates.
	Specialist visit	$20 **copayment** / visit	$40 **copayment** / visit	Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to $20 **copayment**/visit, unless you consent to the non-PPO billing rates.
	Preventive care/screening/immunization	No charge for routine physicals or **Preventive Services** as defined in the **Plan;** no coverage for immunizations for adults that are not **Preventive Services**	40% **co-insurance**, except routine physicals will be covered at 100% of the PPO contracted rate; no coverage for immunizations for adults that are not **Preventive Services**	See SPD for definition of **Preventive Services.** Coverage for a Well Child service provided by a non-PPO **provider** or that is not a **Preventive Service** is limited to $75/exam, $75/inoculation and $50/lab service. Non-PPO coverage limited to **UCR**. You may have to pay for services that aren't preventive. Ask your **provider** if the services needed are preventive Then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% **co-insurance;** no charge for **Preventive Services**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
	COVID-19 Test (including over the counter tests)	20% **co-insurance**	40% **co-insurance**	No **Preauthorization** required.
	Imaging (CT/PET scans, MRIs)	20% **co-insurance**; no charge for **Preventive Services**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	No charge	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order). When available, generic drugs will be substituted for formulary brand drugs, unless a treating physician specifically authorizes the use of a formulary brand drug. **Preauthorization** is required for **Specialty drugs**. Certain brand drugs are subject to step therapy which requires you to first try a more cost effective therapeutically equivalent drug.
	Preferred Brand Drugs	$10 **copay** retail; $20 **copay** mail order	Not covered	
	Non-preferred brand drugs	$40 **copay** retail; $80 **copay** mail order	Not covered	
	Specialty drugs	$40 **copay** retail; $80 **copay** mail order	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **co-insurance**	40% **co-insurance**	Prior authorization required or benefits may not be paid. Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% **co-insurance**, unless you consent to the non-PPO billing rates.
	Physician/surgeon fees	20% **co-insurance**	40% **co-insurance**	

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
If you need immediate medical attention	**Emergency room care**	20% **co-insurance**	20% **co-insurance**	You will have to pay 40% **co-insurance** after $200 deductible for emergency services at a non-PPO facility if (1) you did not have an emergency medical condition; or (2) you receive emergency services for treatment of an emergency medical condition from a non-PPO provider or non-PPO emergency facility and consent to the non-PPO billing rate for certain post-stabilization services. Non-PPO coverage limited to **UCR**.
	Emergency medical transportation	20% **co-insurance**	20% **co-insurance**;	Non-PPO coverage limited to **UCR**.
	Urgent care	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **co-insurance**	40% **co-insurance**	Prior authorization required or benefits may not be paid. Non-PPO coverage limited to **UCR**.
	Physician/surgeon fee	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% **co-insurance**, unless you consent to the non-PPO billing rates.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 **copay** (office visits); 20% **co-insurance** (other than office visits)	$20 **copay** (office visits); 40% **co-insurance** (other than office visits)	Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to $10 **copay** for office visits; 20% **co-insurance** for services other than office visits, unless you consent to the non-PPO billing rates.
	Inpatient Services	20% **co-insurance**	40% **co-insurance**	For substance use disorder inpatient services, first confinement without prior outpatient treatment covered at 100% **in-network**. Non-PPO coverage limited to **UCR**. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 20% **co-insurance** unless you consent to the non-PPO billing rates.
If you are pregnant	Office visits	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Childbirth/delivery professional services	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Childbirth/delivery facility services	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
If you need help recovering or have other special health needs	**Home health care**	20% **co-insurance**	40% **co-insurance**	Prior authorization required for non-PPO **providers** or benefits may not be paid. Non-PPO coverage limited to **UCR**.
	Rehabilitation services	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Habilitation services	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Skilled nursing care	20% **co-insurance**	40% **co-insurance**	Prior authorization required or benefits may not be paid. Coverage is limited to a maximum of 50% of local **UCR**.
	Durable medical equipment	20% **co-insurance**	40% **co-insurance**	Non-PPO coverage limited to **UCR**.
	Hospice services	20% **co-insurance**	40% **co-insurance**	Prior authorization required for non-PPO **providers** or benefits may not be paid. Non-PPO coverage limited to **UCR**.
If your child needs	Children's eye exam	$10 **co-pay**	Covered up to $45	Limited to one exam per year.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations & Exceptions
dental or eye care	Children's glasses	$10 **co-pay** for lenses, $150 frame allowance	Covered to $100 depending on lens type; $70 frame allowance	Limited to one pair of lenses per year and one set of frames every 2 years.
	Children's dental check-up	20% **co-insurance** after $50 **deductible**	20% **co-insurance** after $50 **deductible**	The maximum benefit for dental services per calendar year is $2,000.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services).

- Acupuncture
- Cosmetic surgery, except within 12 months after and as the result of an injury, for the
- Non-emergency care when traveling outside the U.S
- Routine foot care
- Correction of a congenital defect of a dependent child, or for replacement of diseased tissue surgically removed
- Treatment that is not medically necessary, except for covered **Preventive Services**
- Hearing aids
- Infertility treatment
- Long term care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.

- Bariatric surgery within Medicare national coverage guidelines
- Chiropractic care
- Dental care (Adult)
- Private duty nursing, with prior utilization review.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agency in the chart below. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care and Department of Insurance at 980 9th St, Suite #500 Sacramento, CA 95814, 1-888-466-2219 or http://www.HealthHelp.ca.gov.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Administrative Office	1-888-208-0250 or www.bac3tilebenefits.org
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.healthhelp.ca.gov/

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al **1-888-208-0250**.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-208-0250**.

如果需要中文的帮助，请拨打这个号码 **1-888-208-0250**.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-208-0250**.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
The plan's overall deductible	$250	The plan's overall deductible	$250	The plan's overall deductible	$250
Specialist coinsurance	20%	Specialist coinsurance	20%	Specialist coinsurance	20%
Hospital (facility)	20%	Hospital (facility)	20%	Hospital (facility)	20%
Other (blood work)	20%	Other (blood work)	20%	Other (x-ray)	20%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (*prenatal care*)		**Primary care physician** office visits (*including disease education*)		**Emergency room care** (*including medical supplies*)	
Childbirth/Delivery Professional Services		**Diagnostic tests** (*blood work*)		**Durable medical equipment** (*crutches*)	
Childbirth/Delivery Facility Services		**Prescription drugs**		**Diagnostic test** (*x-ray*)	
Diagnostic tests (*ultrasounds and blood work*)		**Durable medical equipment** (*glucose meter*)		**Rehabilitation services** (*physical therapy*)	
Specialist visit (*anesthesia*)					
Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		***Cost Sharing***		***Cost Sharing***	
Deductibles	$250	**Deductibles**	$250	**Deductibles**	$250
Copays	$0	**Copays**	$300	**Copays**	$60
Coinsurance	$1,000	**Coinsurance**	$100	**Coinsurance**	$400
What isn't covered		***What isn't covered***		***What isn't covered***	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$1,310**	**The total Joe would pay is**	**$670**	**The total Mia would pay is**	**$710**

Northern California Tile Industry Trust Funds

Health & Welfare • Vacation & Holiday • Defined Benefit Pension • Defined Contribution Pension

Northern California Tile Industry Health and Welfare Plan
PRIVACY PRACTICES NOTICE
May 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction. Health plans are required to protect the confidentiality of health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes the Northern California Tile Industry Health and Welfare Plan's practices and policies with respect to your confidential health information. This notice does not address the privacy practices and policies of your health care providers (doctors, HMOs, etc.).

I. RESPONSIBILITIES OF THE PLAN

A. The Northern California Tile Industry Health and Welfare Plan is required by law to:

1. protect the privacy of your health information;

2. provide you with this notice describing our legal duties to keep your health information private, as well as your rights to access your health information;

3. notify affected individuals following a breach of unsecured protected health information; and

4. follow the terms set out in this notice for as long as it is in effect.

B. The Plan reserves the right to change the terms of this notice and make new provisions for the protection of your health information. However, if any change is made to the way your health information is used or disclosed, the Plan will notify you by sending you a new privacy practices notice to replace this one, or by sending you information about the change and how to obtain a copy of the Plan's new privacy practices notice.

II. USES AND DISCLOSURES

A. The Plan is REQUIRED by law to disclose your health information, even without your written authorization, in the following circumstances:

1. To you, if you request it.

2. When required by the Secretary of the Department of Health and Human Services to determine whether the Plan has adequately protected the privacy of your medical records.

B. The Plan is ALLOWED by law to use or disclose your health information without your written authorization for the following purposes. The Plan is prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes.

1. Treatment. The Plan may disclose information to the doctors and hospitals that you have gone to for health care. *For example, if you are unable to provide your medical history to an emergency room doctor, the Plan may disclose to the doctor the types of prescription drugs you currently take.*

2. For Substance Use and Disorder Treatment. The Plan may use or disclose your substance use and disorder treatment records or testimony relaying the content of such records to public health authorities, provided that the records disclosed are properly de-identified. However, the Plan may not use or disclose substance use and disorder treatment records or testimony relaying the content of such records in civil, criminal, administrative, and legislative proceedings against you, absent your written consent or a court order.

3. Payment for health care services. The Plan may use and disclose information so that claims for health care treatment, services and supplies you receive may be paid according to the Plan's terms. *For example, the Plan may need to know what treatment or supplies you received from your doctor, before it can reimburse your doctor for the services.*

4. Health care operations. The Plan may need to use some of your health information for its own internal purposes. *For example, the Plan may use some of your health information to conduct compliance audits, or to determine what coverage the Plan should provide.*

5. Reports to the Plan sponsor. The Plan may disclose information to the Board of Trustees so they can carry out their Plan-related administrative functions. The Plan's documents have been amended to ensure that the Board protects the privacy of such information.

6. Disclosures to the Plan's Business Associates. The Plan uses Business Associates to provide certain services to the Plan, such as administrative, legal, accounting, or health care services. The Plan may disclose health information to a Business Associate, where the Business Associate has agreed in writing to appropriately safeguard that information.

7. For public health activities and purposes, such as reporting communicable diseases to health authorities, as required by law.

8. To report child abuse, neglect or domestic violence, to the extent required by law.

9. To coroners, medical examiners and funeral directors, as necessary to carry out their duties.

10. For health oversight activities, such as audits or civil and criminal investigations of the Plan or health care providers.

11. In response to a court order, subpoena, discovery request, or other lawful process, if certain conditions for protecting your privacy are met.

12. For some law enforcement activities, such as complying with a law enforcement official's request for limited information to identify a suspect or missing person.

13. For research purposes, so long as specific conditions are met to guarantee your privacy.

14. To avert a serious threat to the health or safety of a person or of the public, consistent with applicable law.

15. For organ, eye or tissue donation purposes.

16. To comply with workers' compensation laws.

17. For the creation, renewal or replacement of a contract of health insurance or health benefits. If the contract is not created, renewed or replaced, your health information will not be used for any other purpose, except as required by law.

18. For specialized government functions, such as military and veterans' activities, national security or intelligence, or correctional institutions.

19. For other uses required by law.

C. The Plan is ALLOWED to disclose your health information in the following circumstances ONLY if you have given the Plan a valid authorization:

1. Any use or disclosure of psychotherapy notes, except in certain situations as specified by law;

2. For marketing by the Plan, except for face-to-face communications and gifts of nominal value. However, this Plan does no marketing; and

3. For a sale of protected health information. However, this Plan does not sell protected health information.

D. The Plan is ALLOWED to disclose your health information in the following circumstances ONLY if you have been given the opportunity to prohibit or restrict the use or disclosure, or if you are not present or are incapable of making medical decisions, and the Plan believes it is in your best interest:

1. For use in a directory of patients in a health care facility.

2. To your family members, friends or other person designated by you, if they are participating in your treatment or making decisions with you or on your behalf.

3. To notify your family members, personal representative or another person responsible for your care of your general condition, location or death.

III. The Plan is NOT ALLOWED to use or disclose your health information without a written authorization from you for any purpose other than the ones listed in this notice. If you authorize a disclosure, you have the right to revoke the authorization. The revocation must be in writing.YOUR RIGHTS

You have the right to:

A. Request restrictions on the Plan's use and disclosure of your information to carry out treatment, payment or health care operations. You may also request restrictions on the use and disclosure to family members, relatives, friends or other persons identified by you who are involved in your care. However, the Plan is not required to agree to your requested restriction.

B. Receive confidential communications regarding your health information by reasonable alternative means or at reasonable alternative locations, if you let the Plan know that the disclosure of all or part of that information could endanger you. The Plan may require that you provide it with information on how payment, if any, will be handled and may require that you provide it with an alternative address or way of contacting you.

C. Inspect and copy your health information;

D. Amend your health information, if it is incomplete or incorrect;

E. Receive an accounting (list) of all of the disclosures of your health information made by the Plan, other than those allowed under the regulations, during the past six years;

F. Obtain a paper copy of this notice, if you have received this notice electronically.

In order to exercise any of these rights, you should contact the Plan's privacy officer, at the address and phone number listed in Section V below. The privacy officer will explain the Plan's procedure for exercising any of your rights listed above. You may be required to submit your request to the Plan in writing.

IV. COMPLAINTS

A. You have the right to file a complaint with the Plan if you believe that the Plan has violated your privacy rights as described in this notice. To file a complaint with the Plan, send a written complaint, including all of the information relevant to your complaint, to the Plan Administration Office at the following address:

Northern California Tile Industry Health and Welfare Plan
c/o BeneSys Administrators
Attn: Privacy Officer
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

B. You also have the right to file a complaint with the Secretary of Health and Human Services if you believe that the Plan has violated your privacy rights, as described in this notice.

C. The Plan will not retaliate against you for filing a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

V. CONTACT INFORMATION

A. You may obtain more information regarding this notice and the privacy practices of the Plan by contacting:

Privacy Officer
Northern California Tile Industry Health and Welfare Plan
c/o BeneSys Administrators
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566
(925) 208-9995

VI. FEDERAL REGULATIONS

This Notice is intended as a summary and explanation of information and rules contained in the federal privacy regulations. For further information about your privacy rights, you may consult those regulations, at 45 C.F.R. Parts 160 and 164.

VII. THIS NOTICE IS EFFECTIVE AS OF JANUARY 1, 2026.

This document has been uploaded and is available on the participant website at:
www.bac3tilebenefits.org

Northern California Tile Industry Trust Funds

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May 2026

ANNUAL NOTIFICATION WOMEN'S HEALTH AND CANCER-RIGHTS ACT OF 1998

Your Health and Welfare Plan is required by federal law to provide you annually with the following notice, which applies to breast cancer patients who elect to have reconstructive surgery in connection with a mastectomy.

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for reconstructive surgery, as requested by the patient in consultation with the attending physician for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

This coverage is subject to the Plan's deductibles, coinsurance, or co-payment provisions.

If you have any questions about your Plan's coverage for mastectomies or reconstructive surgery, please contact the Trust Fund Office at (925) 208-9995. Thank you.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Your Health and Welfare Plan requires group coverage to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after delivery by cesarean section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate. If you are discharged earlier, your physician may decide, at his or her discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider whose scope of practice includes postpartum care and newborn care.

If you have any questions about your Plan's coverage, please contact the Trust Fund Office at (925) 208-9995. Thank you.

NOTICE OF AVAILABILITY OF PLAN'S NOTICE OF PRIVACY PRACTICES

The Northern California Tile Industry Health & Welfare Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. You may obtain a copy of the Notice of Privacy Practices by making a written request for such to the Trust Fund Office as follows:

Northern California Tile Industry
P.O. Box 1607
San Ramon, CA 94583

Within a reasonable period of time of your request, the Trust Fund Office will mail you a copy of the Notice. Alternatively, you may phone the Trust Fund Office at (925) 208-9995, to request that a copy be mailed to you.

This document has been uploaded and is available on the participant website at:
www.bac3tilebenefits.org

7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566
P.O. Box 1607 San Ramon, CA 94583
Phone 925.208.9995 • Toll Free 888.208.0250 • Facsimile 925.462-0108
www.bac3tilebenefits.org • staff@bac3tilebenefits.org

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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 March 17, 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

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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

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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

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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 March 17, 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.

OMB Control Number 1210-0137 (expires 1/31/2026)

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 925-208-9995 (TTY: 711) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 925-208-9995 (TTY: 711) o hable con su proveedor.

中文 (Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 925-208-9995（文本电话： 711）或咨询您的服务提供商。

Tiếng Việt (Vietnamese) LƯU Ý: Nếu bạn nói một ngôn ngữ khác, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các dịch vụ và trợ giúp bổ sung phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng có sẵn miễn phí. Gọi 925-208-9995 TTY: 711 hoặc nói chuyện với nhà cung cấp của bạn.

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 925-208-9995 (TTY: 711) o makipag-usap sa iyong provider.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 925-208-9995 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք այլ լեզվով, ձեզ հասանելի են անվճար լեզվական աջակցության ծառայություններ: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համար համապատասխան օժանդակ օժանդակ միջոցներն ու ծառայությունները նույնպես հասանելի են անվճար: Զանգահարեք 925-208-9995 (TTY: 711) կամ խոսեք ձեր մատակարարի հետ

فارسی (Persian) توجه: اگر به زبان دیگری صحبت می کنید، خدمات کمک زبان رایگان برای شما در دسترس است. خدمات کمک ی و کمک ی مناسب برای ارائه اطلاعات در قالب های قابل دسترس نیز به صورت رایگان در دسترس هستند. با 925-208-9995 (TTY: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 925-208-9995 (TTY: 711) или обратитесь к своему поставщику услуг.

日本語 (Japanese) 注意: 別の言語を話す場合は、無料の言語支援サービスをご利用いただけます。アクセシブルな形式で情報を提供するための適切な補助手段やサービスも無料でご利用いただけます。925-208-9995 (TTY: 711) に電話するか、プロバイダーにお問い合わせください。

العربية (Arabic)
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 925-208-9995 TTY: 711أو تحدث إلى مقدم الخدمة.

ਗੁਰਮੁਖੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੀਆਂ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 925-208-9995 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖
ប្រសិនបើអ្នកនិយាយភាសាផ្សេង
សេវាជំនួយភាសាឥតគិតថ្លៃអាចរកបានសម្រាប់អ្នក។ ជំនួយ និងសេវាជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើបានក៏អាចរកបានដោយឥតគិតថ្លៃដែរ។
ទូរស័ព្ទទៅ 925-208-9995 (TTY: 711)
ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Hmoob (Hmong) CEEB TOOM: Yog tias koj hais lwm hom lus, muaj kev pabcuam lus pub dawb rau koj. Cov kev pabcuam tsim nyog thiab cov kev pabcuam los muab cov ntaub ntawv hauv cov qauv siv tau kuj muaj pub dawb. Hu rau 925-208-9995 (TTY: 711) lossis tham nrog koj tus kws kho mob.

हिंदी (Hindi) ध्यान दें: यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। 925-208-9995 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ภาษาไทย (Thai) หมายเหตุ: หากคุณพูดภาษาอื่น คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี นอกจากนี้ ยังมีบริการช่วยเหลือและบริการเสริมที่เหมาะสมเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โปรดโทร 925-208-9995 (TTY: 711) หรือพูดคุยกับผู้ให้บริการของคุณ

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