Northern California Tile Industry Trust Funds
P.O. Box 1607
San Ramon, CA 94583
(888) 208-0250
(925) 208-9995
www.bac3tilebenefits.org

Enhanced Member Benefit Website
www.bac3tilebenefits.org

Dear Member:

The Trustees of the Northern California Tile Industry Trust Funds are pleased to announce a new enhanced member benefit website, www.bac3tilebenefits.org. This website has been fully updated to provide you with a more effective way to access and manage your benefits.

The website enables you to obtain basic benefit information about the Plan, review answers to frequently asked questions, access your personal benefit information, and communicate with the Benefit Office via e-mail. You can also find helpful links regarding benefits provided by the Plan.

To access your personal benefit information, such as your benefit elections, work history detail, forms, and Plan documents, you need to register as a new user by clicking the *Create an Account* link at the top right hand corner in the Login box. More detailed instructions are shown on the back of this letter. Once you are registered, you can access your personal benefit information by entering your ***User Name*** and ***Password***, so please keep these confidential. **Please note, only one user name and password is permitted per email address. If more than one person in your family requires website access, each must use a different email address.**

Every member, spouse, and dependent over the age of 18 will need to create their own login that will give them access to their own Protected Health Information (PHI). Each person that creates their own username and password will not have their PHI available for viewing by any other user.

Please contact the Benefit Office at (888) 208-0250 if you encounter any difficulty logging in, or if you have any questions regarding the Member Benefit website. You can also email the Benefit Office directly by using the "Contact Us" section of the website.

Please visit the enhanced Member Benefit website soon and see all that it has to offer!

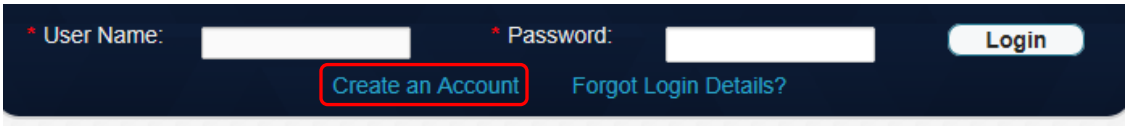
Board of Trustees,

Northern California Tile Industry Trust Funds

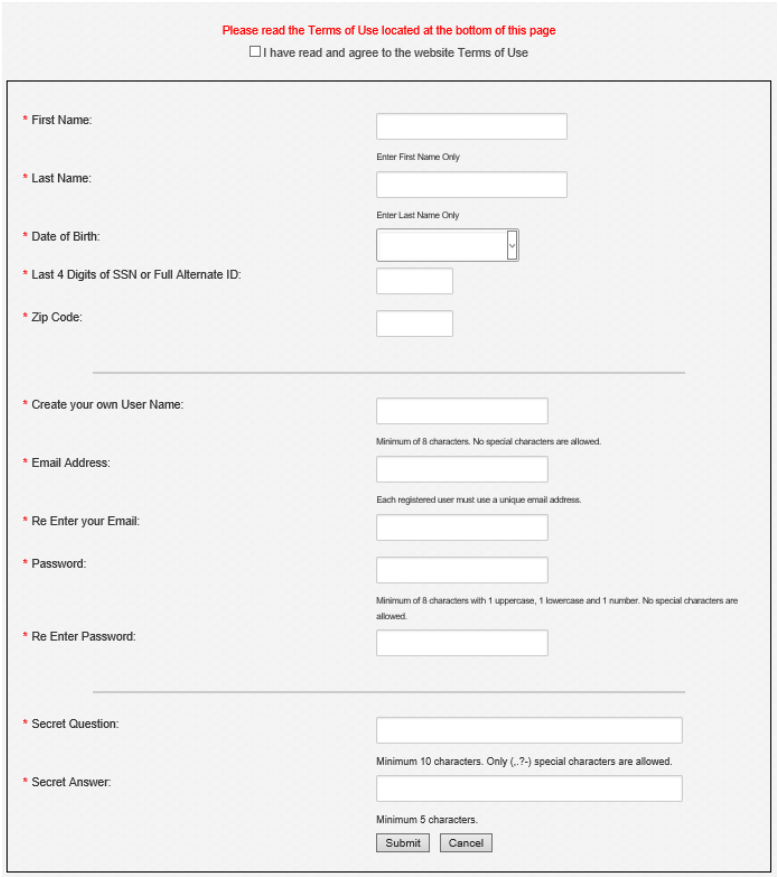
HOW TO REGISTER ON THE WEBSITE

When registering for the first time, please follow these instructions:

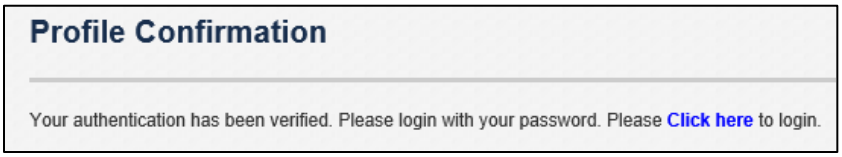
1) From your computer or mobile device, connect to the website listed on the front page of this letter.
2) Locate the Login box in the upper right-hand corner of the screen.
3) Click on "Create an Account" to get started.



4) The Registration Screen will display next. Please enter all information, as all fields are required. Once all information has been entered, please click "Submit" on the bottom of the screen.



5) After registering you will receive an email notification with a link to confirm your registration. Your email address will also be used in the event you forget your user name and password.



Northern California Tile Industry Trust Funds

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

New Member Enrollment Package Contents

This enrollment package was sent to you because you are, or will be eligible for health care coverage. In order to better understand the benefits that are available to you, it is important that you carefully read all of the information included. It is equally important that you fully and legibly complete and return all required documents as soon as possible. Any missing information or incomplete forms will delay the processing of your medical and/or dental claims.

Enclosed please find:

Health Care Plan Document	This book contains the rules of the Plan and a description of the benefits available to you and your dependents.
Enrollment Forms	This is required for all new participants. The Enrollment Form must be **completed** and returned to the address below as soon as possible. This will stop any delay in processing claims because of missing information.
Coordination of Benefits Form	This is required for all participants. Complete this form if you, your spouse, or any of your dependents have/do not have, other health insurance coverage. If you and/or your dependent(s) **do not** have other coverage, please check the indicator box and sign/date the bottom of the page under "Member Statement" and return to the Trust Fund Office.
Notice of the Privacy Practices (HIPAA) and Authorization Form	Please read the enclosed HIPAA Privacy notice, which explains your rights, and how and when medical information may be disclosed. Effective April 2003 you will no longer receive health care information over the phone for any member of your family other than *yourself* or your minor child (under age 18), **unless a signed authorization form is on file at this office. Please complete and sign the enclosed Authorization for Release of Protected Health Information form and return it to the Fund Office.**
Notices of COBRA Continuation Coverage Rights	**It is very important that you and your spouse read the information regarding your health care coverage if it is terminated. These are known as your "COBRA Rights" and are explained in the Health Care Plan Document and a notice contained in this package.**
Dental Plan	Dental Benefits are provided through the self-funded PPO plan. Please review your Summary Plan Description to find the benefit coverage available to you and the exclusions that apply to the Plan.
Vision Plan	Vision Benefits are provided through Vision Service Plan ("VSP") to all employees. Please see the enclosed benefit summary sheet regarding VSP.

-OVER-

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

SAV-RX Prescription

Prescriptions are provided through SAV-RX. Please review the enclosed SAV-RX formulary list and reimbursement form.

Additional pharmacy information may be obtained by visiting the SAV-RX website at www.savrx.com or by calling SAV-RX Customer Service at 1-800-228-3108.

Note: If you choose the Kaiser medical plan, prescription coverage will be provided through Kaiser.

Identification Cards

I.D. Cards will be ordered as soon as we receive the completed Enrollment Form Applications.

Monthly Status Reports: This statement will be mailed to you around the second week of each month. This statement gives you important information about your eligibility for Health Care Coverage and also provides you with a record of hours and contributions as reported by your employer. **It is important that you carefully review this report each month.**

****YOU MUST PROVIDE A COPY OF YOUR MARRIAGE CERTIFICATE TO ADD YOUR SPOUSE AND BIRTH CERTIFICATE(S) TO ADD DEPENDENT CHILD(REN). ****

PLEASE RETURN ALL FORMS TO:

NORTHERN CALIFORNIA TILE INDUSTRY
P.O. BOX 1607
SAN RAMON, CA 94583

Northern California Tile Industry Trust Funds

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

NEW MEMBER PACKET CHECK LIST
FORMS TO BE RETURNED TO THE TRUST FUND OFFICE:

(It may not be necessary to complete all of the listed below, depending on your coverage choices. Please contact the Trust Fund Office if you should have any questions regarding your enrollment.)

☐	**Enrollment Form**	This is required for all Participants.
☐	**Coordination of Benefits Form**	This is required for all Participants. Complete this form if you, your spouse, or any of your dependents have/do not have other insurance Benefits.
☐	**Authorization for Release of Protected Health Information**	It is strongly recommended that you, your spouse and your eligible dependents over the age of 18 complete the Authorization for Release of Protected Health Information (PHI) Form.
☐	**Beneficiary Designation Form**	It is strongly recommended that you complete the Beneficiary Designations to ensure that death benefits are paid according to your wishes.
☐	**Marriage Certificate**	If you are married, please submit a photo copy of your marriage certificate to your current spouse.
☐	**Declaration of Domestic Partnership**	If you have a registered Domestic Partner, please submit a photocopy of your Declaration of Domestic Partnership.
☐	**Birth Certificates**	Please submit photo copies of birth certificates for: You, your Spouse/Domestic Partner; and any Dependent Children you wish to enroll onto the Plan (including step-children and adopted children).

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

This Page Intentionally Left Blank

Northern California Tile Industry Trust Funds

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

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:** _____

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

This Page Intentionally Left Blank

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:** _____

Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Member/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Member Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-
   If you are not married or **you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself". **Please sign and date below the box**.

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).
   If you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box**.

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
   If want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box**.

-OVER-

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, (print your name and Social Security number) _____ **authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

Northern California Tile Industry Health and Welfare Plan
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 • Fax 925-462-0108
www.bac3tilebenefits.org • staff@bac3tilebenefits.org

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member_____**Date Signed:** _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member_____**Date Signed**: _____

SPOUSE SECTION

I, the **spouse** (**Name, Please Print**) _____, (**Spouse's Social Security #**) _____of the above named member, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse_____ **Date Signed**: _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse_____ **Date Signed**: _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the **dependent child(ren)** over the age of 18 (**Name, Please Print)**_____,**(Social Security #)** _____have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent_____**Date Signed**: _____

OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Dependent_____**Date Signed**: _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Benefit Office.

Northern California Tile Industry Trust Funds

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

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

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

Northern California Tile Industry Trust Funds

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

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** _____

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

Northern California Tile Industry Trust Funds

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

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)

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

This Page Intentionally Left Blank

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/.
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	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** provided by a **PPO Provider**
- 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**

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. No Charge for Contraceptives.
	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	2-hour limit / visit, 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.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:

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)

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-757-7585 (TTY: 711)

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 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) copayment** **$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) copayment** **$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	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

- **The plan's overall deductible** **$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	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

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

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully 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 Service Contact Center at **1 800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (except closed holidays). If you cannot hear or speak well, please call **711**.

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

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You may also speak with a Member Services representative about the options that apply to you. Please call Member Services if you need help filing a grievance.

You may submit a discrimination grievance in the following ways:

- **By phone:** Call member services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays)
- **By mail:** Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you
- **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 Coordinators 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:

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

  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 for 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

  Complaint forms are available at:
  http:www.hhs.gov/ocr/office/file/index.html
- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Aviso de no discriminación

La discriminación es ilegal. Kaiser Permanente cumple con las leyes de los derechos civiles federales y estatales.

Kaiser Permanente no discrimina ilícitamente, excluye ni trata a ninguna persona de forma distinta por motivos de edad, raza, identificación de grupo étnico, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, género, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, condición médica, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

Kaiser Permanente ofrece los siguientes servicios:

- Ayuda y servicios sin costo a personas con discapacidades para que puedan comunicarse mejor con nosotros, como lo siguiente:
    - ♦ intérpretes calificados de lenguaje de señas,
    - ♦ información escrita en otros formatos (braille, impresión en letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Servicios de idiomas sin costo a las personas cuya lengua materna no es el inglés, como:
    - ♦ intérpretes calificados,
    - ♦ información escrita en otros idiomas.

Si necesita nuestros servicios, llame a nuestra Central de Llamadas de Servicio a los Miembros al **1-800-464-4000** (TTY **711**) las 24 horas del día, los 7 días de la semana (excepto los días festivos). Si tiene deficiencias auditivas o del habla, llame al **711**.

Este documento estará disponible en braille, letra grande, casete de audio o en formato electrónico a solicitud. Para obtener una copia en uno de estos formatos alternativos o en otro formato, llame a nuestra Central de Llamadas de Servicio a los Miembros y solicite el formato que necesita.

Cómo presentar una queja ante Kaiser Permanente

Usted puede presentar una queja por discriminación ante Kaiser Permanente si siente que no le hemos ofrecido estos servicios o lo hemos discriminado ilícitamente de otra forma. Consulte su *Evidencia de Cobertura (Evidence of Coverage) o Certificado de Seguro (Certificate of Insurance)* para obtener más información. También puede hablar con un representante de Servicio a los Miembros sobre las opciones que se apliquen a su caso. Llame a Servicio a los Miembros si necesita ayuda para presentar una queja.

Puede presentar una queja por discriminación de las siguientes maneras:

- **Por teléfono:** llame a Servicio a los Miembros al **1 800-464-4000** (TTY **711**), las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- **Por correo postal:** llámenos al **1 800-464-4000** (TTY **711**) y pida que se le envíe un formulario.
- **En persona:** llene un formulario de Queja o reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte su directorio de proveedores en kp.org/facilities [cambie el idioma a español] para obtener las direcciones).
- **En línea:** utilice el formulario en línea en nuestro sitio web en kp.org/espanol.

También puede comunicarse directamente con el coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente a la siguiente dirección:

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

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California *(Solo para beneficiarios de Medi-Cal)*

También puede presentar una queja sobre derechos civiles ante la Oficina de Derechos Civiles (Office of Civil Rights) del Departamento de Servicios de Atención Médica de California (California Department of Health Care Services) por escrito, por teléfono o por correo electrónico:

- **Por teléfono:** llame a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica (Department of Health Care Services, DHCS) al **916-440-7370** (TTY **711**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  Los formularios de queja están disponibles en:
  http://www.dhcs.ca.gov/Pages/Language_Access.aspx (en inglés).

- **En línea:** envíe un correo electrónico a CivilRights@dhcs.ca.gov.

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU.

Puede presentar una queja por discriminación ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. (U.S. Department of Health and Human Services). Puede presentar su queja por escrito, por teléfono o en línea:

- **Por teléfono:** llame al **1-800-368-1019** (TTY **711** o al **1-800-537-7697**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

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

  Los formularios de quejas están disponibles en
  http://www.hhs.gov/ocr/office/file/index.html (en inglés).

- **En línea:** visite el Portal de quejas de la Oficina de Derechos Civiles en:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf (en inglés).

反歧視聲明

歧視是違反法律的行為。Kaiser Permanente 遵守州政府與聯邦政府的民權法。

Kaiser Permanente 不因年齡、人種、族群認同、膚色、原國籍、文化背景、祖籍、宗教、生理性別、社會性別、性認同、性表現、性取向、婚姻狀況、身體或精神殘障、病況、付款來源、遺傳資訊、公民身份、母語或移民身份而非法歧視、排斥或差別對待任何人。

Kaiser Permanente 提供下列服務：

- 為殘障人士提供免費協助與服務以幫助其更好地與我們溝通，例如：
    - ♦ 合格手語翻譯員
    - ♦ 其他格式的書面資訊（盲文版、大字版、語音版、通用電子格式及其他格式）
- 為母語非英語的人士提供免費語言服務，例如：
    - ♦ 合格口譯員
    - ♦ 其他語言的書面資訊

如果您需要上述服務，請打電話 1-800-464-4000 (TTY 711) 給會員服務聯絡中心，每週 7 天，每天 24 小時（節假日除外）。如果您有聽力或語言困難，請打電話 711。

若您提出要求，我們可為您提供本文件的盲文版、大字版、錄音卡帶或電子格式。如要得到上述一種替代格式或其他格式的版本，請打電話給會員服務聯絡中心並索取您需要的格式。

如何向 Kaiser Permanente 投訴

如果您認為我們未能提供上述服務或有其他形式的非法歧視行為，您可向 Kaiser Permanente 提出歧視投訴。請參閱您的《承保範圍說明書》*(Evidence of Coverage)* 或《保險證明》*(Certificate of Insurance)* 瞭解詳情。您也可以向會員服務部代表諮詢適用於您的選項。如果您在投訴時需要協助，請打電話給會員服務部。

您可透過下列方式投訴歧視：

- **電話：** 打電話 1 800-464-4000 (TTY 711) 聯絡會員服務部，每週 7 天，每天 24 小時（節假日除外）
- **郵寄：** 打電話 1 800-464-4000 (TTY 711) 與我們聯絡，要求將投訴表寄給您
- **親自提出：** 在保險計劃下屬設施的會員服務辦公室填寫投訴或索賠／申請表（請在 kp.org/facilities 網站的保健業者名錄上查詢地址）
- **線上：** 使用 kp.org 網站上的線上表格

您也可直接與 Kaiser Permanente 民權事務協調員聯絡，地址如下：

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

如何向加州保健服務部民權辦公室投訴（僅限 *Medi-Cal* 受益人）

您也可透過書面方式、電話或電子郵件向加州保健服務部民權辦公室提出民權投訴：

- **電話：**打電話 916-440-7370 (TTY 711) 聯絡保健服務部 (DHCS) 民權辦公室
- **郵寄：**填寫投訴表或寄信至：

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  您可在網站上 http://www.dhcs.ca.gov/Pages/Language_Access.aspx 取得投訴表
- **線上：**發送電子郵件至 CivilRights@dhcs.ca.gov

如何向美國健康與民眾服務部民權辦公室投訴

您可向美國健康與民眾服務部民權辦公室提出歧視投訴。您可透過書面、電話或線上提出投訴：

- **電話：**打電話 1-800-368-1019（TTY 711 或 1-800-537-7697）
- **郵寄：**填寫投訴表或寄信至：

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  您可在網站上取得投訴表：
  http:www.hhs.gov/ocr/office/file/index.html 取得投訴表
- **郵寄：**訪問民權辦公室投訴入口網站：
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf。

Thông Báo Không Phân Biệt Đối Xử

Phân biệt đối xử là trái với pháp luật. Kaiser Permanente tuân thủ các luật dân quyền của Tiểu Bang và Liên Bang.

Kaiser Permanente không phân biệt đối xử trái pháp luật, loại trừ hay đối xử khác biệt với người nào đó vì lý do tuổi tác, chủng tộc, nhận dạng nhóm sắc tộc, màu da, nguồn gốc quốc gia, nền tảng văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng giới tính, tình trạng hôn nhân, tình trạng khuyết tật về thể chất hoặc tinh thần, bệnh trạng, nguồn thanh toán, thông tin di truyền, quyền công dân, ngôn ngữ mẹ đẻ hoặc tình trạng nhập cư.
Kaiser Permanente cung cấp các dịch vụ sau:

- Phương tiện hỗ trợ và dịch vụ miễn phí cho người khuyết tật để giúp họ giao tiếp hiệu quả hơn với chúng tôi, chẳng hạn như:
    - ♦ Thông dịch viên ngôn ngữ ký hiệu đủ trình độ
    - ♦ Thông tin bằng văn bản theo các định dạng khác (chữ nổi braille, bản in khổ chữ lớn, âm thanh, định dạng điện tử dễ truy cập và các định dạng khác)
- Dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh, chẳng hạn như:
    - ♦ Thông dịch viên đủ trình độ
    - ♦ Thông tin được trình bày bằng các ngôn ngữ khác

Nếu quý vị cần những dịch vụ này, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi theo số **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ). Nếu quý vị không thể nói hay nghe rõ, vui lòng gọi **711**.

Theo yêu cầu, tài liệu này có thể được cung cấp cho quý vị dưới dạng chữ nổi braille, bản in khổ chữ lớn, băng thu âm hay dạng điện tử. Để lấy một bản sao theo một trong những định dạng thay thế này hay định dạng khác, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi và yêu cầu định dạng mà quý vị cần.

Cách đệ trình phàn nàn với Kaiser Permanente

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử với Kaiser Permanente nếu quý vị tin rằng chúng tôi đã không cung cấp những dịch vụ này hay phân biệt đối xử trái pháp luật theo cách khác. Vui lòng tham khảo Chứng Từ Bảo Hiểm (Evidence of Coverage) hay Chứng Nhận Bảo Hiểm (Certificate of Insurance) của quý vị để biết thêm chi tiết. Quý vị cũng có thể nói chuyện với nhân viên ban Dịch Vụ Hội Viên về những lựa chọn áp dụng cho quý vị. Vui lòng gọi đến ban Dịch Vụ Hội Viên nếu quý vị cần được trợ giúp để đệ trình phàn nàn.

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử bằng các cách sau đây:

- **Qua điện thoại:** Gọi đến ban Dịch Vụ Hội Viên theo số **1-800-464-4000** (TTY **711**) 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ)
- **Qua thư tín:** Gọi chúng tôi theo số **1-800-464-4000** (TTY **711**) và yêu cầu gửi mẫu đơn cho quý vị
- **Trực tiếp:** Hoàn tất mẫu đơn Than Phiền hay Yêu Cầu Thanh Toán/Yêu Cầu Quyền Lợi tại văn phòng dịch vụ hội viên ở một Cơ Sở Thuộc Chương Trình (truy cập danh mục nhà cung cấp của quý vị tại kp.org/facilities để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại kp.org

Quý vị cũng có thể liên hệ trực tiếp với Điều Phối Viên Dân Quyền của Kaiser Permanente theo địa chỉ dưới đây:

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

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California *(Dành Riêng Cho Người Thụ Hưởng Medi-Cal)*

Quý vị cũng có thể đệ trình than phiền về dân quyền với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California bằng văn bản, qua điện thoại hay qua email:

- **Qua điện thoại:** Gọi đến Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế (Department of Health Care Services, DHCS) theo số **916-440-7370** (TTY **711**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

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

  Mẫu đơn than phiền hiện có tại: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**

- **Trực tuyến:** Gửi email đến CivilRights@dhcs.ca.gov

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ.

Quý vị cũng có quyền đệ trình than phiền về phân biệt đối xử với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ. Quý vị có thể đệ trình than phiền bằng văn bản, qua điện thoại hoặc trực tuyến:

- **Qua điện thoại:** Gọi **1-800-368-1019** (TTY **711** hay **1-800-537-7697**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

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

  Mẫu đơn than phiền hiện có tại
  http:www.hhs.gov/ocr/office/file/index.html

- **Trực tuyến:** Truy cập Cổng Thông Tin Than Phiền của Văn Phòng Dân Quyền tại:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

NOTICE OF LANGUAGE ASSISTANCE

English: This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000 (TTY 711)** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays. We can also help you with auxiliary aids and alternative formats.

Arabic: تحتوي هذه الوثيقة على معلومات مهمة من Kaiser Permanente. إذا كنت بحاجة للمساعدة في فهم هذه المعلومات، يرجى الاتصال على الرقم **(TTY: 711) 1-800-464-4000**وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية. يمكننا أيضاً تزويدك بمساعدات إضافية وتنسيقات بديلة.

Armenian: Սա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրում ենք զանգահարել **1-800-464-4000 (TTY 711)** հեռախոսահամարով և օժանդակություն ստանալ լեզվի հարցում: Զանգահարեք օրը 24 ժամ, շաբաթը 7 օր՝ բացի տոն օրերից: Մենք նաև կարող ենք օգնել Ձեզ օժանդակ օգնության և այլընտրանքային ձևաչափերի հարցում:

Chinese: 這是來自 Kaiser Permanente 的重要資訊。如果您需要協助瞭解此資訊，請致電 **1-800-757-7585 (TTY 專線 711)** 尋求語言協助。我們每週 7 天，每天 24 小時皆提供協助（節假日休息）。我們還可以幫助您獲取輔助設備和其它格式。

Farsi: این اطلاعات مهمی از سوی Kaiser Permanente می باشد. اگر در فهمیدن این اطلاعات به کمک نیاز دارید، لطفاً با شماره **1-800-464-4000 (TTY 711)** تماس گرفته و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانروز و 7 روز هفته، شامل روزهای تعطیل موجود است. ما همچنین می توانیم برای شما کمکهای جانبی و به صورتهای دیگر را فراهم کنیم.

Hindi: यह Kaiser Permanente की ओर से महत्वपूर्ण सूचना है। यदि आपको इस सूचना को समझने के लिए मदद की जरूरत है, तो कृपया **1-800-464-4000 (TTY 711)** पर फोन करें और भाषा सहायता के लिए पूछें। सहायता छुट्टियों को छोड़कर, सप्ताह के सातों दिन, दिन के 24 घंटे, उपलब्ध है। हम सहायक साधनों और वैकल्पिक प्रारूपों को प्राप्त करने में भी आपकी मदद कर सकते हैं।

Hmong: Qhov xov xwm no tseem ceeb los ntawm Kaiser Permanente. Yog koj xav tau kev pab kom nkag siab cov xov xwm no, thov hu rau **1-800-464-4000 (TTY 711)** thiab thov kev pab txhais lus. Muaj kev pab 24 teev ib hnub twg, 7 hnub ib lim tiam twg, tsis xam cov hnub caiv. Peb kuj muab tau lwm yam kev pab rau koj thiab ua lwm yam ntaub ntawv.

Japanese: Kaiser Permanente から重要なお知らせがあります。この情報を理解するためにヘルプが必要な場合は、**1-800-464-4000 (TTY 回線 711)** に電話して、言語サービスを依頼してください。このサービスは年中無休（祝祭日を除く）でご利用いただけます。補助器具・サービスや別のフォーマットについてもご相談いただけます。

Khmer:នេះគឺជាព័ត៌មានសំខាន់ មកពី Kaiser Permanente។ បើសិនអ្នកត្រូវការជំនួយ ឲ្យបានយល់ដឹងព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខ **1-800-464-4000 (TTY 711)** និងស្នើសុំជំនួយខាងភាសា។ ជំនួយគឺមាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ លើកលែងថ្ងៃឈប់សម្រាក។
យើងក៏អាចជួយអ្នកជាមួយនឹងឧបករណ៍ជំនួយទំនាក់ទំនងសម្រាប់អ្នកពិការនិងជាទម្រង់ជំនួសផ្សេងៗ។

Korean: 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, **1-800-464-4000 (TTY 711)** 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외). 또한 보조기구 및 대체 형식의 자료를 지원해 드릴 수 있습니다.

Laotian: ນີ້ແມ່ນຂໍ້ມູນສຳຄັນຈາກ Kaiser Permanente. ຖ້າວ່າ ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການຊ່ວຍໃຫ້ເຂົ້າໃຈຂໍ້ມູນນີ້, ກະຣຸນາໂທຣ **1-800-464-4000 (TTY 711)** ແລະຂໍເອົາການຊ່ວຍເຫຼືອດ້ານພາສາ. ການຊ່ວຍເຫຼືອມີໃຫ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ບໍ່ລວມວັນພັກຕ່າງໆ. ພວກເຮົາຍັງສາມາດຊ່ວຍທ່ານໃນ ດ້ານອຸປະກອນຊ່ວຍເສີມ ແລະ ຮູບແບບທາງເລືອກອື່ນໄດ.

Mien: Naaiv se benx jienv sic dauh waac-fienx yiem naaiv Kaiser Permanente bun daaih. Beiv taux meih qiemx longc mienh tengx doqc naaiv deix waac-fienx liouh porv bun bieqc hnyouv nor, daaix luic douc waac daaih lorx **1-800-464-4000 (TTY 711)** aengx caux tov heuc tengx nzie faan waac bun muangx. Mbenc nzoih liouh tengx yiem yietc hnoi benx 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi, simv cuotv hnoi-gec oc. Yie mbuo corc haih mbenc wuotc ginc jaa-dorngx tengx nzie goux aengx caux liouh bun ginv longc sou-guv daan puix horpc meih.

Navajo: Díí éí hane’ bíhólníihii át’éego Kaiser Permanente yee nihalne’. Díí hane’ígíí doo hazhó’ó bik’i’diitįįhgóó t’áá shǫǫdí koji’ hodíílnih **1-800-464-4000 (TTY 711)** áko saad bee áká i’iilyeed yídíikił. Kwe’é áká aná’álwo’ t’áá áłahjį’ naadiindįį’ ahéé’ílkidgóó dóó tsosts’id jį ąą’át’é. Dahodílzingóne’ éí dá’deelkaal. Áádóó hane’ bee bik’i’ di’díítíiłígíí dóó t’áá łahgo át’éego hane’ nich’į ádoolníił.

Punjabi: ਇਹ Kaiser Permanente ਵਲੋਂ ਜ਼ਰੂਰੀ ਜਾਣਕਾਰੀ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ **1-800-464-4000 (TTY 711)** 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁੱਛੋ। ਮਦਦ, ਛੁੱਟੀਆਂ ਨੂੰ ਛੱਡ ਕੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਅਤੇ ਦਿਨ ਦੇ 24 ਘੰਟੇ ਮੌਜੂਦ ਹੈ। ਅਸੀਂ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਵੀ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ।

Russian: Это важная информация от Kaiser Permanente. Если Вам требуется помощь, чтобы понять эту информацию, позвоните по номеру **1-800-464-4000 (линия TTY 711)** и попросите предоставить Вам услуги переводчика. Помощь доступна 24 часа в сутки, 7 дней в неделю, кроме праздничных дней. Мы также можем помочь вам с вспомогательными средствами и альтернативными форматами.

Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-788-0616 (TTY 711)** y pida ayuda linguística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos. También podemos ayudarle con recursos para discapacidades y formatos alternativos.

Tagalog: Ito ay importanteng impormasyon mula sa Kaiser Permanente. Kung kailangan ninyo ng tulong para maunawan ang impormasyong ito, mangyaring tumawag sa **1-800-464-4000 (TTY 711)** at humingi ng tulong kaugnay sa lengguwahe. May makukuhang tulong 24 na oras bawat araw, 7 araw bawat linggo, maliban sa mga araw na pista opisyal. Matutulungan din namin kayo sa mga pantulong na gamit o serbisyo at mga alternatibong format.

Thai: นี่เป็นข้อมูลสำคัญจาก Kaiser Permanente หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อมูลนี้ โปรด โทร **1-800-464-4000 (โหมด TTY 711)** และขอความช่วยเหลือด้านภาษา เราพร้อมให้ความช่วยเหลือตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ ยกเว้นวันหยุดราชการ เรายังสามารถจัดหาอุปกรณ์และวัสดุช่วยเหลือในรูปแบบอื่นได้อีกด้วย

Ukranian: У цьому повідомленні міститься важлива інформація від Kaiser Permanente. Якщо надана інформація не зрозуміла й вам потрібна допомога, зателефонуйте за номером **1-800-464-4000 (TTY 711)** і попросіть надати вам послугу перекладача. Наші співробітники надають допомогу цілодобово, 7 днів на тиждень, за винятком святкових днів. Також ми можемо допомогти вам, надавши допоміжні засоби й матеріали в альтернативних форматах.

Vietnamese: Đây là thông tin quan trọng từ Kaiser Permanente. Nếu quý vị cần được giúp đỡ để hiểu rõ thông tin này, vui lòng gọi số **1-800-464-4000 (TTY 711)** và yêu cầu được cấp dịch vụ về ngôn ngữ. Quý vị sẽ được giúp đỡ 24 giờ trong ngày, 7 ngày trong tuần, trừ ngày lễ. Chúng tôi cũng có thể giúp quý vị với các phương tiện trợ giúp bổ trợ và hình thức thay thế.

A Look at Your VSP Vision Coverage

With VSP and NORTHERN CALIFORNIA TILE INDUSTRY H & W TRUST FUND, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

With private practice doctors and Visionworks retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Create an account today.

Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

NORTHERN CALIFORNIA TILE INDUSTRY H & W TRUST FUND and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
08/01/2024

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 for exam and glasses Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME[+]	• $220 Featured Frame Brands allowance • $200 frame allowance • 20% savings on the amount over your allowance	Combined with exam	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Tints/Light-reactive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175 $0	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $180 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

[†]Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
[‡]Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
[+]Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

SAV-RX
PRESCRIPTION SERVICES

224 North Park Ave • Fremont, NE 68025
Phone: (402) 753-2800 • Fax: (888) 810-1394

Reimbursement Request Form

Note: Please send to the attention of the "Reimbursement Department" when mailing this form to Sav-Rx.

Participant Information

Cardholder Name (See ID Card):		
Cardholder ID (See ID Card):	**Relation to Cardholder**: ☐ **Self** ☐ **Dependent**	
Participant Name:	**Date of Birth**:	
Phone Number:	**Email Address**:	
Address:		
City:	**State**:	**Zip Code**:

Prescription Information

Number of Prescriptions Submitted:	**Date Prescription(s) Filled**:
	(*For multiple prescriptions please use a range from first to last)*
Out-of-Pocket Total:	**Coupon Used At Time Of Processing**: ☐ Yes ☐ No

Reimbursement Information

In the space below, please provide the reason for not utilizing the Sav-Rx card/ submitting this reimbursement request:

Please provide receipts for prescriptions along with this form.

Please note any receipts submitted to Sav-Rx for reimbursement must include the following

- Member Name
- Date of Service
- Drug Name
- Quantity Dispensed
- Amount Patient Paid
- Drug NDC
- Prescription Number

Cardholder Signature

Date

By signing the above, you attest that all information is true to the best of your abilities in seeking reimbursement for medications paid out of pocket and/ or that did not adhere to the benefit structure – resulting in a larger amount paid. You also acknowledge that there is no guarantee of reimbursement for medications that may have required a prior authorization or clinical review prior to dispensing the medication(s).

This Page Intentionally Left Blank

SAV-RX

Prescription Drug Formulary

This condensed formulary is designed to serve as a reference guide and assist in the selection of cost-effective pharmaceutical products. The formulary is not intended to be a substitute for your clinical knowledge and judgement. In all cases, the prescriber is expected to select appropriate drug therapy for the individual patient and provide high quality healthcare. The Sav-Rx Therapeutics Committee reviews this formulary quarterly, to ensure it meets the needs of both patients and providers. **All generics are covered.** Please call 800-228-3108 with any questions or to request an updated version.

ANTI-INFECTIVE AGENTS (ORAL)

ANTIBIOTICS
Amoxicillin/Potassium/Clav. (generic Augmentin/ generic Augmentin ES/generic Augmentin XR)
Tetracyclines
Doxycycline (generics except for 20mg)
Minocycline (generic Minocin/generic Dynacin Cap)
Tetracycline (generic)
Cephalosporins
Avibactam/Ceftazidime (Avycaz)
Cefaclor (generic Ceclor)
Cefadroxil (generic Duricef)
Cefdinir (generic Omnicef)
Cefpodoxime (generic Vantin)
Cefuroxime (generic Ceftin/ Ceftin Suspension)
Cephalexin (generic Keflex)
Taziobactam/Ceftolozane (Zerbaxa)
Erythromycins & Other Macrolides
Azithromycin (generic Zithromax)
Clarithromycin (generic Biaxin/generic Biaxin XL)
Erythromycin (generics)
Quinolones
Ciprofloxacin (generic Cipro/Cipro Susp)
Ciprofloxacin HCl/BetaineComb (Cipro XR)
Levofloxacin (generic Levaquin)
Moxifloxacin (generic Avelox)
Ofloxacin (generic Floxin)
Sulfonamides
Sulfisoxazole (generic)
TMP-SMX SS/DD (generic)
OTHER ANTI-INFECTIVES
Clindamycin HCl (generic Cleocin)
Dapsone (Dapsone)
Ethambutol (generic Myambutol)
Isoniazid (generic)
Linezolid (generic Zyvox)*
Neomycin Sulfate (generic)
Nitrofurantoin (generic Macrodantin/generic Macrobid/ generic Furadantin)
Pyrazinamide (generic)
Quinine Sulfate (generic Qualaquin)
Rifampin (generic Rifadin)
Tobramycin/Sod Chloride 0.2% Ampule for Nebulization (generic Tobi, Bethkis)*
Trimethoprim (generic Trimpex)
Vancomycin HCl (generic Vancocin HCl Cap)*
ANTIFUNGAL AGENTS
Clotrimazole Troche (generic Mycelex)
Fluconazole (generic Diflucan)
Flucytosine (Ancobon)
Griseofulvin (generic Grifulvin Susp/generic Gris-Peg)
Isavuconazonium (Cresemba)*
Itraconazole (generic Sporanox/Sporanox)*
Ketoconazole (generic Nizoral)
Nystatin Oral (generic)
Posaconazole (Noxafil)*
Terbinafine HCl (generic Lamisil)
Voriconazole (generic Vfend Tablet)*
ANTIPARASITICS
Albendazole (Albenza)
Ivermectin (generic Stromectol)
Mebendazole (generic Vermox)
Metronidazole/Metronidazole ER (generic Flagyl/generic Flagyl ER)
Nitazoxanide (Alinia)
Tinidazole (generic Tindamax)

ANTIVIRAL AGENTS*
Acyclovir (generic Zovirax)
Amantadine (generic Symmetrel)
Famciclovir (generic Famvir)
Lamivudine (generic Epivir HBV)
Oseltamivir (Tamiflu)
Peramivir (Rapivab)
Ribavirin (generic Rebetol/Ribasphere/ Ribapak)
Valganciclovir (generic Valcyte)
Zanamivir (Relenza)

HIV/AIDS THERAPY*
Presently, all brand name drugs without generics specifically indicated for the treatment of HIV and its opportunistic infections are on Formulary,subject to plan parameters and applicable copays.

ANTINEOPLASTIC AND IMMUNOSUPPRESSIVE AGENTS*

All oral FDA-approved antineoplastic and immunosuppressive agents are eligible for coverage under the prescription drug benefit, subject to clinical review, plan parameters and applicable copays.

AUTONOMIC AND CENTRAL NERVOUS SYSTEM AGENTS

ANALGESICS, NARCOTIC*
APAP/Hydrocodone (generic Vicodin/generic Norco/ generic Lortab)
Buprenorphine (Butrans Patch)*
Fentanyl (generic Duragesic)*
Hydrocodone ER (Hysingla ER)*
Hydrocodone/Ibuprofen (generic Vicoprofen)
Hydromorphone (generic Dilaudid/generic Dilaudid Liquid)
Morphine Sulfate (generic suppository/generic MSIR)
Morphine Sulfate, ER (generic MS Contin)*
Oxycodone ER (generic Oxycontin)*
Oxycodone IR (generic)
Oxycodone/APAP (generic Percocet)
Oxymorphone ER (generic Opana ER)*
Oxymorphone IR (generic Opana)
Tapentadol (Nucynta/Nucynta ER)
ANALGESICS, NONSTEROIDAL ANTI-INFLAMMATORY
Celecoxib (generic Celebrex)
Diclofenac (generic Voltaren tab/generic Voltaren gel)
Diclofenac Potassium (generic Cataflam)
Ibuprofen (generic Motrin)
Indomethacin (generic Indocin/generic Indocin SR)
Ketoprofen (generic Orudis)
Ketoprofen Cap, 24hr SR Pellet (generic Oruvail)
Meloxicam (generic Mobic)
Nabumetone (generic Relafen)
Naproxen (generic Naprosyn/generic Anaprox/ generic EC Naprosyn)
Naproxen Sodium, SA (generic Naprelan)
Oxaprozin (generic Daypro)
Piroxicam (generic Feldene)
Tolmetin Na (generic Tolectin)
ANALGESICS, SALICYLATES
Choline Salicylate/Mg Salicylate (generic)
Diflunisal (generic Dolobid)
Salsalate (generic)
ANALGESICS, NON-NARCOTIC/ MISCELLANEOUS*
Butorphanol, Spray (generic Stadol)
Eletriptan (Relpax)
Ergotamine Sublingual (Ergomar)
Isometheptene/Dichloralphenazone/APAP (generic Midrin)
Naratriptan HCl (generic Amerge)
Rizatriptan (generic Maxalt/MLT)
Sumatriptan (generic Imitrex, Sumavel Dosepro)
Tramadol (generic Ultram)
Zolmtriptan (generic Zomig/ZMT,Zomig Nasal Spray)
ANTIVERTIGO/ANTIEMETICS
Aprepitant (Emend)*
Dolasetron Mesylate Tablet (Anzemet)*
Granisetron HCl (generic Kytril Tab)*
Meclizine HCl (generic Antivert)
Netupitant/Palonosetron (Akynzeo)
Ondansetron (generic Zofran/generic Zofran ODT)*
Prochlorperazine (generic Compazine)
Promethazine HCl (generic Phenergan)
Trimethobenzamide (generic Tigan)
ALZHEIMER'S AGENTS
Donepezil (generic Aricept/generic Aricept ODT)
Donepezil/Memantine (Namzaric)
Galantamine (generic Razadyne IR & ER)
Memantine (generic Namenda)
Rivastigmine (generic Exelon/Exelon Patch)
ANTIPARKINSON AGENTS
Amantadine (generic Symmetrel)
Benztropine Mesylate (generic)
Bromocriptine (generic Parlodel)
Carbidopa (generic Lodosyn)
Carbidopa/Levodopa, SR (generic Sinemet) generic Sinemet CR)
Entacapone (generic Comtan)
Pergolide Mesylate (generic Permax)
Pramipexole Di-HCl (genericMirapex/Mirapex ER)
Rasugiline (Azilect)
Ropinirole HCl (generic Requip/ generic Requip XL)
Selegiline (generic Eldepryl)
Trihexyphenidyl (generic)
ANTICONVULSANTS
Carbamazepine, SR (generic Tegretol/generic Tegretol XR)
Clonazepam (generic Klonopin)
Diazepam Rectal Gel (generic Diastat)
Divalproex Na (Depakote Sprinkle/generic Depakote /Depakote ER)
Ethosuximide (generic Zarontin)
Ethotoin (Peganone)
Felbamate (generic Felbatol)
Gabapentin/Gabapentin Soln, Oral (generic Neurontin)
Lacosamide (Vimpat)
Lamotrigine (generic Lamictal XR)
Levetiracetam (generic Keppra)
Methsuximide (Celontin)
Perampanel (Fycompa)
Phenobarbital (generic)
Phenytoin/Phenytoin Extended (generic Dilantin/Dilantin 30mg, 50mg & generic Susp)
Pregabalin (Lyrica)
Primidone (generic Mysoline)
Topiramate (generic Topamax)
Valproic Acid (generic Depakene)
MUSCLE RELAXANTS/ANTISPASMODICS
Baclofen (generic)
Carisoprodol (generic Soma)
Chlorzoxazone (generic Parafon Forte DSC)
Cyclobenzaprine HCl (generic Flexeril)
Dantrolene Sodium (generic Dantrium)
Metaxalone (generic Skelaxin)
Methocarbamol (generic Robaxin)
Neostigmine Bromide (Prostigmin Tab)
Pyridostigmine (generic Mestinon)
Tizanidine (generic Zanaflex)

ANXIOLYTICS, SEDATIVES AND HYPNOTICS
Alprazolam (generic Xanax)
Buspirone (generic BuSpar)
Chloral Hydrate (generic)
Chlordiazepoxide HCl (generic Librium)
Clorazepate (generic Tranxene)
Diazepam (generic Valium)
Estazolam (generic Prosom)
Eszopiclone (generic Lunesta)*
Flurazepam (generic Dalmane)
Hydroxyzine Pamoate (generic Vistaril)
Lorazepam (generic Ativan)
Oxazepam (generic Serax)
Ramelteon (Rozerem)*
Temazepam (generic Restoril)
Triazolam (generic Halcion)
Zaleplon (generic Sonata)*
Zolpidem (generic Ambien)*
PSYCHOTHERAPEUTIC AGENTS
Antidepressants
Amitriptyline (generic Elavil)
Bupropion/Bupropion SR (generic Wellbutrin/generic Wellbutrin SR)
Buproprion XL (generic Wellbutrin XL)
Citalopram (generic Celexa)
Desipramine (generic Norpramin)
Desvenlafaxine (generic, Pristiq)
Doxepin (generic Sinequan)
Duloxetine (generic Cymbalta)
Fluoxetine (generic Prozac)
Imipramine (generic Tofranil)
Imipramine (generic Tofranil-PM)
Levomilnacipran (Fetzima)
Milnacipran (Savella)
Mirtazapine (generic Remeron/ generic Remeron SolTab)
Nortriptyline (generic Pamelor)
Paroxetine HCl (generic Paxil/generic Paxil CR/ Paxil Susp)
Phenelzine (generic Nardil)
Sertraline HCl (generic Zoloft)
Trazodone (generic Desyrel)
Trimipramine (Surmontil)
Venlafaxine (generic Effexor/generic Effexor XR)
Vilazodone (Viibryd)
Antipsychotic Agents
Aripipazole (generic Abilify)
Chlorpromazine (generic)
Clozapine (generic Clozaril)
Fluphenazine (generic Prolixin)
Haloperidol (generic Haldol)
Loxapine (generic Loxitane)
Lurasidone (Latuda)
Olanzapine (generic Zyprexa/Zydis)
Perphenazine (generic)
Pimozide (generic Orap)
Quetiapine (generic Seroquel/Seroquel XR)
Risperidone (generic Risperdal, Risperdal Consta)
Thiothixene (generic Navane)
Trifluoperazine (generic Stelazine)
Ziprasidone (generic Geodon)
MISCELLANEOUS PSYCHOTHERAPEUTICS*
Amphetamine Salt Combo (generic Adderall/Adderall XR)
Armodafinil (generic Nuvigil)
Atomoxetine HCl (Strattera)
Buprenorphine/Naloxone (generic SL tablet, Suboxone Film/Zubsolv)
Clomipramine (generic Anafranil)
D-Amphetamine Sulfate (generic Dexedrine)
Dexmethylphenidate (generic Focalin/Focalin XR)
Fluvoxamine (generic Luvox)
Guanfacine ER (generic Intuniv)
Lisdexamfetamine (Vyvanse)
Lithium Carbonate (generic Eskalith/ generic Eskalith CR/generic Lithobid)
Lithium Citrate (generic)
Methylphenidate HCl ER (generic Concerta/generic Metadate-CD/Daytrana patch, Quillivant XR susp)
Methylphenidate IR/SR (generic Ritalin/generic Ritalin SR)
Modafinil (generic Provigil)
Naltrexone (generic tablet, Vivitrol injection)

CARDIOVASCULAR AGENTS

ANTIARRHYTHMICS
Amiodarone (generic Cordarone)
Digoxin (generic Lanoxin)
Disopyramide (generic Norpace/generic Norpace CR)
Dofetilade (generic Tikosyn)*
Flecainide Acetate (generic Tambocor)
Mexiletine (generic Mexitil)
Procainamide HCl (generic Pronestyl)
Procainamide, SR (generic Procanbid)
Propafenone HCl (generic Rythmol)
Quinidine Gluconate (generic)
Quinidine Sulfate (generic Quinidex)
Sotalol (generic Betapace/generic Betapace AF/ Sotylize*)
VASODILATORS
Isosorbide Din (generic Isordil)
Isosorbide Mono (generic ISMO/generic Imdur)
Nitroglycerin Patch(generic Transderm-Nitro/ Nitro-Dur)
Nitroglycerin SL/SA Cap/Oint (Nitrostat/Nitro-Bid)
ANTICOAGULANTS/ANTITHROMBOTICS*
Anagrelide (generic Agrylin)
Apixaban (Eliquis)
ASA/ER Dipyridamole (generic Aggrenox)
Cilostazol (generic Pletal)
Clopidogrel (generic Plavix)
Dabigatran Etexilate (Pradaxa)
Dalteparin Na, Porcine (Fragmin)*
Dipyridamole (generic Persantine)
Enoxaprin (generic Lovenox)*
Fondaparinux Na (generic Arixtra)
Prasugrel (Effient)
Rivaroxaban (Xarelto)
Pentoxifylline Tablet, SA (generic Trental)
Ticagrelor (Brilinta)
Ticlopidine HCl (generic Ticlid)
Warfarin Sodium (generic Coumadin)
BETA BLOCKERS
Acebutolol (generic Sectral)
Atenolol (generic Tenormin)
Betaxolol (generic Kerlone)
Bisoprolol (generic Zebeta)
Carvedilol (generic Coreg/ Coreg CR)
Labetalol (generic Trandate)
Metoprolol (generic Lopressor)
Metoprolol, SR (generic Toprol XL)
Nadolol (generic Corgard)
Nebivolol (Bystolic)
Pindolol (generic)
Propranolol (generic Inderal/generic Inderal LA)
CALCIUM CHANNEL BLOCKERS
Amlodipine (generic Norvasc)
Diltiazem (generic Cardizem)
Diltiazem, SR (generic Cardizem CD/ generic Dilacor XR)
Felodipine (generic Plendil)
Nifedipine Tablet SR (generic)
Verapamil(generic Calan)
Verapamil, SR (generic Calan SR/generic Verelan)
Verapamil, PM (generic Verelan PM)
THIAZIDE & RELATED DIURETICS
Acetazolamide (generic Diamox)
Amiloride HCl/HCTZ (generic Moduretic)
Bumetanide (generic Bumex)
Chlorthalidone (generic)
Furosemide (generic Lasix)
Hydrochlorothiazide (generic)
Indapamide (generic Lozol)
Metolazone (generic Zaroxolyn)
Spironolactone/Spironolactone HCTZ (generic Aldactone/generic Aldactazide)
Torsemide (generic Demadex)
Triamterene/HCTZ (generic Maxzide/ generic Dyazide)
ACE INHIBITORS
Benazepril (generic Lotensin)
Captopril (generic Capoten)
Enalapril (generic Vasotec)
Fosinopril (generic Monopril)
Lisinopril (generic Prinivil)
Quinapril (generic Accupril)
Ramipril (generic Altace)
ANGIOTENSIN II ANTAGONISTS
Candesartan (generic Atacand)
Irbesartan (generic Avapro)
Losartan (generic Cozaar)
Olmesartan (generic Benicar)
Valsartan (generic Diovan)
ADRENERGIC ANTAGONISTS/RELATED DRUGS
Clonidine (generic Catapres)
Clonidine Patch (generic Catapres TTS)
Doxazosin Mesylate (generic Cardura)
Guanfacine (generic Tenex)
Methyldopa (generic)
Prazosin HCl (generic Minipress)
Terazosin (generic Hytrin)
CARDIOVASCULAR COMBINATIONS
Aliskiren/HCTZ (Tekturna HCT)
Amlodipine/Benazepril (generic Lotrel)
Amlodipine/Olmesartan (generic Azor)
Amlodipine/Valsartan/HCTZ (generic Exforge HCT)
Amlodipine/Olmesartan/HCTZ (Tribenzor)
Atenolol/Chlorthalidone (generic Tenoretic)
Benazepril/HCTZ (generic Lotensin HCT)
Bisoprolol/HCTZ (generic Ziac)
Candesartan/HCTZ (generic Atacand HCT)
Captopril/HCTZ (generic Capozide)
Enalapril/HCTZ (generic Vaseretic)
Fosinopril/HCTZ (generic Monopril HCT)
Irbesartan/HCTZ (generic Avalide)
Lisinopril/HCTZ (generic Prinzide)
Losartan/HCTZ (generic Hyzaar)
Metoprolol/HCTZ (generic Lopressor HCT)
Olmesartan/HCTZ (generic Benicar HCT)
Propranolol/HCTZ (generic Inderide)
Quinapril/HCTZ (generic Accuretic)
Sacubitril/Valsartan (Enresto)
Telmisartan/Amlodipine(generic Twynsta)
Trandolapril/Verapamil (generic Tarka)
Valsartan/HCTZ (generic Diovan HCT)
MISC CARDIOVASCULAR AGENTS
Aliskiren (Tekturna)
Ambrisentan (Letairis)*
Bosentan (Tracleer)*
Epoprostenol (Flolan)*
Iloprost (Ventavis)*
Ivabradine HCl (Corlanor)*
Macitentan (Opsumit)*
Ranolazine (Ranexa)*
Sildenafil (generic Revatio)*
Treporstinil (Remodulin)*
ANTILIPIDEMICS
Atorvastatin (generic Lipitor)
Cholestyramine (generic Questran/ generic Questran Light)
Colesevelam HCl (Welchol tabs, powder in packet)
Ezetimibe (Zetia)
Ezetimibe/Simvastatin (Vytorin)
Fenofibrate (generic Tricor/generic Trilipix/generic Antara/Lipofen)
Gemfibrozil (generic Lopid)
Icosapent Ethyl (Vascepa)
Lovastatin (generic Mevacor)
Niacin, SA Sequential (generic Niaspan)
Omega-3-Acid Ethylesters (generic Lovaza)
Pravastatin (generic Pravachol)
Rosuvastatin (generic Crestor)
Simvastatin (generic Zocor)

*** May be subject to Prior Authorization Requirements and/or Quantity Limitations as determined by your plan parameters.**

——————DERMATOLOGICALS——————

TOPICAL CORTICOSTEROIDS ——————
Low Potency
Aclometasone Dip Cr/Int (generic Aclovate)
Desonide Cr/Lot/Oint(genericTridesilon/generic Desowen)
Fluocinolone (generic Synalar/Capex Shampoo)
Hydrocortisone Cr/Lot/Oint (generic Hytone 2.50%)
Medium Potency
Betamethasone Valerate Cream/Lotion (generic)
Desoximetasone Cream (generic Topicort 0.05%)
Fluocinolone Acetonide Cream/Oint
(generic Synalar 0.025%)
Fluticasone Oint/Cream (generic Cutivate 0.005%)
Hydrocortisone Val Cr/Oint (generic Westcort 0.20%)
Mometasone Oint/Cr/Lot (generic Elocon)
Triamcinolone Acetonide Cream/Oint/Lotion
(generic Kenalog)
High Potency
Betamethasone Dip Cream/Ointment)
(generic Diprolene/generic Diprolene AF)
Betamethasone Val Oint (generic)
Desoximetasone Cream/Oint/Gel(generic Topicort)
Diflorasone (generic Psorcon 0.05%)
Triamcinolone Acetonide Cr/Oint
(generic Kenalog 0.50%)
Very High Potency
Clobetasol Cr/Gel/Oint/Soln(generic Temovate)
Diflorasone Oint (generic Psorcon 0.05%)
Halobetasol (generic Ultravate)

THERAPY FOR ACNE/ROSACEA ——————
Adapalene (generic Differin)*
Adapalene/Benzoyl Peroxide (Epiduo/Epiduo Forte)*
Azelaic Acid (Azelex/Finacea)*
Brimonidine Tartrate (Mirvaso)*
Clindamycin (generic Cleocin T)
Clindamycin/Benzoyl Peroxide (generic Benzaclin/generic Duac CS/Acanya/Onexton)*
Clindamycin/Tretinoin gel (generic Ziana)*
Doxycycline monohydrate (generic Oracea)*
Erythromycin Base/Ethyl Alcohol (generic)
Erythromycin-Benzoyl Peroxide Gel
(generic Benzamycin)
Isotretinoin (Absoric/Amnesteem/Claravis)*
IMetronidazole (generic Metrocream)
Sulfacetamide Na/Sulfur (generic Sulfacet-R/generic Plexion)
Tazarotene (Tazorac)*
Tretinoin (generic Retin-A/Atralin)*

TOPICAL ANTIBACTERIALS ——————
Gentamicin (generic)
Mupirocin (generic Bactroban)

TOPICAL ANTIFUNGALS ——————
Butenafine HCl (Mentax)
Ciclopirox (generic Penlac*/generic Loprox)
Clotrimazole/Betameth (generic Lotrisone)
Econazole (generic Spectazole)
Ketoconazole (generic Nizoral)

TOPICAL ANTIVIRALS——————
Acyclovir (generic Ointment/Zovirax Cream)

ANTIPSORIATRICS/ANTISEBORRHEIC———
Acitretin (generic Soriatane)*
Calcipotriene (generic Dovonex)*
Calcipotriene/Betamethasone (generic Taclonex)
Calcitriol (generic Vectical)
Selenium Sulfide (generic Selsun Rx)

TOPICAL ANESTHETICS——————
Lidocaine Jel/Oint/Soln (generic Xylocaine)
Lidocaine Patch (generic Lidoderm Patch)*

MISCELLANEOUS DERMATOLOGICALS———
Hydrocortisone/Lidocaine (generic Anamantle HC 0.5-3%/generic Anamantle HC Forte)
Imiquimod cream (generic Aldara)
Mafenide (Sulfamylon)
Methoxsalen (Oxsoralen/Ultra)
Permethrin (generic Elimite)
Pimecrolimus (Elidel)*
Podofilox (generic Condylox)
Silver Sulfadiazine (generic Silvadene)
Spinosad (generic Natroba)
Tacrolimus (generic Protopic)*
Trypsin/Balsam Peru/Castor Oil(generic Granulex)
Urea (generic Keralac)

——MISCELLANEOUS OTIC PREPARATIONS——

Acetic Acid/Acetic Acid HC (generic)
Antipyrine/Benzocaine/Glycerin(generic Auralgan)
Benzocaine (generic Oticaine/generic Americaine)
Ciprofoxacin/Dexamethasone (Ciprodex)
Neomycin Sulf/Polymyxin B/HC(generic Cortisporin)

——————ENDOCRINE/DIABETES——————

ANTITHYROID AGENTS——————
Methimazole (generic Tapazole)
Propylthiouracil (generic)

THYROID HORMONES——————
Levothyroxine (generic Synthroid)
Liothyronine (generic Cytomel)
Thyroid (generic Armour Thyroid)

ADRENAL HORMONES——————
Cortisone Acetate (generic)
Fludrocortisone (generic Florinef Acetate)
Prednisolone (generic)
Prednisone (generic)

MISCELLANEOUS HORMONES*——————
Danazol (generic Danocrine)
Fluoxymesterone (generic)
Methyltestosterone(Methitest)
Testosterone (generic Androgel/Axiron/generic Deptestosterone)*

DIABETES THERAPY——————
INSULIN THERAPY
Human Insulin (Humulin/Humulin Mix)
Insulin Glargine (Lantus)
Insulin Lispro (Humalog/Humalog Mix)
Insulin Degludec (Tresiba)

MISCELLANEOUS DIABETIC THERAPY————
Exenatide (Byetta/Bydureon)*
Pramlintide (Symlin)*

ORAL HYPOGLYCEMIC AGENTS ——————
Acarbose (generic Precose)
Canagliflozin (Invokana)
Canagliflozin/Metformin (Invokamet)
Dapagliflozin/Metformin (Xigduo XR)
Empagliflozin/Linagliptin (Glyxambi)
Glimepiride (generic Amaryl)
Glipizide (generic Glucotrol/generic Glucotrol XL)
Glipizide/Metformin HCl (generic Metaglip)
Glyburide (generic Micronase/generic Glynase)
Glyburide/Metformin (generic Glucovance)
Linagliptin (Tradjenta)
Linagliptin/Metformin (Jentadueto/Jentodueto XR)
Metformin HCl (generic Glucophage/generic Glucophage XR)
Nateglinide (generic Starlix)
Pioglitazone HCl (generic Actos)
Pioglitazone/Metformin (generic Actoplus Met)
Repaglinide (generic Prandin)
RepAglinide/Metformin (generic Prandimet)
Sitagliptin (Januvia)
Sitagliptin/Metformin (Janumet/Janumet XR)
Sitagliptin/Simvastatin (Juvisync)

GLUCOSE ELEVATING AGENTS——————
Glucagon/Glucagon, Human Recomb(Glucagen Hypokit,Glucagon)

INSULIN SYRINGES/MISCELLANEOUS DME*——
Blood Sugar Diagnostic Strip (One Touch, One Touch Verio)
Lancets (One Touch)
Insulin Disposable Needles and Pen Needles (Novofine, B-D)
Syringe w-Needle, Disposable, Insulin (B-D)

GASTROINTESTINAL AGENTS

ULCER THERAPY ——————
Cimetidine Tab/Liquid (generic Tagamet)
Esomeprazole (generic Nexium)
Famotidine (generic Pepcid)
Misoprostol (generic Cytotec)
Nizatidine (generic Axid/Axid Soln)
Omeprazole (generic Prilosec)
Ranitidine HCl (generic Zantac/Zantac Syrup)
Sucralfate Tablets (generic Carafate/Carafate Susp)

ANTIDIARRHEALS/ANTISPASMODICS/GI MOTILITY
Belladonna Alkaloids/PB (generic Donnatal)
Clidinium/Chlordiazepoxide (generic Librax)
Dicyclomine (generic Bentyl)
Diphenoxylate/Atropine (generic Lomotil)
Hyoscyamine (generic Levsin/generic Levsin SL/generic Levsinex/generic Levbid)

MISCELLANEOUS GI AGENTS ——————
Alosetron (generic Lotronex)
Balsalazide (generic Colazal)
Budesonide Cap, SR 24hr (generic Entocort EC/Uceris)
HC Supp, Rectal (generic Anusol-HC)
Lactulose (generic Enulose/Generlac)
Lubriprostone (Amitiza)
Mesalamine (Asacol HD/Delzicol/Canasa/Lialda/Pentasa)
Mesalamine Enema/Supp, Rectal (generic Rowasa)
Metoclopramide (generic Reglan)
Naloxegol (Movantik)*
Pancrealipase (Zenpep, Creon,Pancrelipase)
Ursodiol (generic Actigall)

BOWEL EVACUANTS——————
Polyethylene Glycol 3350 (generic Miralax)
Citric Acid/Magnesium/Sodium Picosulfate (Prepopik)
Sodium/Potassium/Mag Sulfate (Suprep)
Sod Sulf/Sod Bicarb/KCl/PEG's (generic/GoLYTELY)
Sodium Chloride/Sodium Bicarbonate/Potassium Chloride/Polyethylene Glycol (Halflytely/NuLYTELY)

BIOTECHNOLOGY DRUGS*

ERYTHROID/MYELOIDSTIMULANTS*——————
Darbepoetin Alfa (Aranesp)
Epoetin Alfa (Procrit)
Filgrastim (Neupogen/Granix)
Pegfilgrastim (Neulasta)
Sargramostim (Leukine)

INTERFERONS*——————
Glatiramer Acetate (Copaxone 40mg)
Interferon Alfa-2b, Recombinant (Intron A)
Interferon Beta-1a (Avonex)
Interferon Beta-1a/Albumin Human (Rebif)
Interferon Beta-1b (Extavia)
Interferon Gamma-1b, Recombinant (Actimmune)
Peginterferon Alfa-2a (Pegasys)
Peginterferon Beta-1a (Plegridy)

RHEUMATOLOGY/GOUT THERAPY

Adalimumab (Humira)*
Allopurinol (generic Zyloprim)
Auranofin (Ridaura)
Azathioprine (generic Imuran)
Colchicine (Colcrys)
Etanercept (Enbrel)*
Febuxostat (Uloric)
Golumumab (Simponi)*
Hydroxychloroquine(generic Plaquenil)
Leflunomide (generic Arava)*
Methotrexate Sodium (generic Rheumatrex/Trexall)
Probenecid (generic)
Sulfasalazine (generic)
Ustekinumab (Stelara)*

OSTEOPOROSIS THERAPY

Alendronate Sodium (generic Fosamax)
Calcitonin, Salmon, Synthetic (Fortical NS)
Ibandronate (generic Boniva Tab)
Raloxifene HCl (generic Evista)
Risedronate (generic Actonel, Atelvia)
Teriparatide (Forteo)*

OBSTETRICS AND GYNECOLOGY*

Desogestrel-Ethinyl Estradiol (generic Cyclessa/Velivet/Cesia)
Desogestrel-Ethinyl Estradiol(generic Ortho-Cept)
Desogestrel-Ethinyl Estradiol/Ethinyl Estradiol (generic Mircette)
Ethinyl Estradiol/Drospirenone (generic Yasmin/generic YAZ/Safyral/generic Beyaz)
Ethynodiol D-Ethinyl Estradiol(generic Demulen)
Levonorgestrel-Ethinyl Estradiol(Seasonique/generic Alesse/generic Nordette/generic Triphasil/generic Seasonale/LoSeasonique)
Norethindrone A-E Estradiol (generic Loestrin)
Norethindrone A-E Estradiol/Ferrous Fumarate (generic Loestrin Fe/LoLoestrin Fe)
Norethindrone-Ethinyl Estradiol(generic Ortho-Novum 1-0.035mg/generic Ortho-Novum 7/7/7)
Norethindrone-Mestranol
(generic Ortho-Novum 1-0.05mg)
Norgestimate-Ethinyl Estradiol (generic Ortho Tri-Cyclen/generic Ortho-Cyclen)
Norgestrel-Ethinyl Estradiol (Ogestrel/generic Lo/Ovral)
Estradiol Valerate-Dienogest (Natazia)

Progestin Only——————
Norethindrone (generic Micronor)

Diaphragms/Other Non-Oral Contraceptives——
Etonogestrel/Ethinyl Estradiol Vaginal Ring (Nuvaring)

ESTROGENS & PROGESTINS——————
Progestins——————
Medroxyprogesterone (generic Provera/generic Depo-Provera)
Norethindrone Acetate (generic Aygestin)
Progesterone (generic)
Progesterone, Micronized (generic Prometrium)

Estrogens——————
Estradiol Gel (Divigel)
Estradiol Patch, TD Biweekly(generic Vivelle Dot)
Estradiol Patch, TD Weekly (generic Climara)
Estradiol Tab (generic Estrace)
Estradiol Vaginal Cream (Estrace)
Estradiol Vaginal Tab (Vagifem)
Estrogens, Conjugated (Premarin cream/tablets/Enjuvia)
Estrogens, Conjugated/Bazedioxifene (Duavee)
Estropipate (generic Ogen)

Estrogen Combinations——————
Estradiol/Norethindrone (Combipatch)
Estrogens,Conjugated/Medroxyprogesterone (Premphase/Prempro)

ANTIESTROGENS——————
Ospemifene (Osphena)
Tamoxifen (generic Nolvadex)

EMERGENCY CONTRACEPTION——————
Levonorgestrel (Plan B One-Step/Next Choice)

TOPICAL VAGINAL PRODUCTS——————
Butoconazole (Gynazole-1)
Miconazole (generic Monistat 3)
Nystatin (generic)
Sulfanilamide (AVC)
Terconazole Cream/Supp (generic Terazol)

OPHTHALMOLOGY

BETA-BLOCKER OPHTHALMOLOGICS——
Betaxolol HCl (generic Betoptic)
Carteolol HCl (generic Ocupress)
Levobunolol (generic Betagan)
Metipranolol (generic OptiPranolol)
Timolol Maleate (generic Timoptic/generic Timoptic-XE)

OTHER GLAUCOMA DRUGS——————
Bimatoprost (Lumigan)
Brimonidine/Timolol (Combigan)
Brinzolamide/Brimonidine (Simbrinza)
Carbachol (Isopto Carbachol)
Dorzolamide HCl (generic Trusopt)
Latanoprost (generic Xalatan)
Pilocarpine HCl (generic Isopto Carpine/Pilopine HS)
Timolol /Dorzolamide (generic Cosopt)
Travoprost (Travatan Z)

NSAID OPHTHALMOLOGICS ——————
Diclofenac Sodium (generic)
Flurbiprofen Sodium (generic Ocufen)
Nepafenac (Nevanac)

VASOCONSTRICTOR DECONGESTANT OPHTHALMOLOGICS——————
Naphazoline HCl (generic Albalon)
Phenylephrine HCl (generic Neo-Synephrine)

ANTIBIOTIC OPHTHALMOLOGICS——————
Bacitracin (generic)
Bacitracin/Poly B (generic Polysporin)
Besifloxcin (Besivance)
Ciprofloxacin (generic Ciloxan/Ciloxan oint)
Erythromycin (generic)
Gentamicin Sulfate (generic)
Levofloxacin (generic Iquix)
Moxifloxacin (Vigamox, Moxeza)
Natacyn (Natamycin)
Neomycin/Gram D/Poly B Drops(generic)
Ofloxacin (generic Ocuflox)
Polymyxin B/Trimethoprim (generic Polytrim)
Sulfacetamide (generic)
Tobramycin (generic Tobrex/Tobrex Ointment)

STEROID OPHTHALMOLOGICS——————
Dexamethasone (generic)
Fluocinolone (Retisert)
Fluorometholone (generic FML/FML S.O.P.)
Loteprednol (Alrex/Lotemax)
Prednisolone (generic Pred Forte/Pred Mild))

STEROID-ANTIBIOTIC OPHTHALMOLOGICS——
Neomycin/Bacitracin/Poly B/HC Oint/Drops (generic Cortisporin)
Neomycin/Poly B/Dex (generic Maxitrol)
Sulfacetamide/Prednisolone (generic Blephamide/Blephamide S.O.P.)
Tobramycin/Dex (generic TobraDex/TobraDex ST)
Tobramycin/Loteprednol (Zylet)

SYMPATHOMIMETIC OPHTHALMOLOGICS———
Brimonidine Tartrate (generic Alphagan)
Dipivefrin HCl (generic Propine)

MISCELLANEOUS OPHTHALMOLOGICS————
Bepotastine (Bepreve)
Cyclosporine (Restasis)*
Hydroxypropyl Methylcellulose (Lacrisert)
Olopatadine HCl (generic Patanol/Pataday/Pazeo)

RESPIRATORY, ALLERGY, COUGH & COLD

ANTIHISTAMINES/ANTIALLERGENIC————
Desloratadine (generic Clarinex/Clarinex Syrup)
Desloratadine/Pseudoephedrine (Clarinex-D)
Hydroxyzine HCl (generic Atarax)
Levocetirizine (generic Xyzal)

COUGH & COLD COMBINATIONS ——————
Hydrocodone/Homatropine (generic Hycodan)
Hydrocodone Polistirex/Chlorpheniramine (generic Tussionex)
Hydrocodone/PSE/Chlorpheniramine (generic)
Bromphen/PSE/DM (generic)
Promethazine/Codeine (generic)

PULMONARY AGENTS——————
Xanthines
Aminophylline (generic)
Theophylline Anhydrous (genericTheo-Dur/Theochron/Elixophylline)

Beta Agonists Oral ——————
Albuterol Sulfate (generic)
Ephedrine Sulfate (generic)
Metaproterenol Sulfate (generic)
Terbutaline (generic Brethine)

Beta Agonists Inhalers* ——————
Albuterol HFA (Ventolin HFA)
Formoterol (Foradil/Perforomist)
Indacaterol (Arcapta Neohaler)
Levalbuterol (generic Xopenex)
Salmeterol Disk (Serevent Diskus)

Inhaled Corticosteroids* ——————
Beclomethasone (QVAR)
Budesonide Powder/Amp (Pulmicort Flexhaler/generic Pulmicort)
Fluticasone (Arnuity Ellipta)
Mometasone (Asmanex HFA)

INTRANASAL AGENTS* ——————
Flunisolide (generic Nasarel)
Fluticasone (generic Flonase/Veramyst)
Mometasone (generic Nasonex)
Triamcinolone acetonide (generic Nasacort)

MISCELLANEOUS RESPIRATORY AGENTS —
Acetylcysteine (generic Mucomyst)
Albuterol/Ipratropium (Combivent Respimat/generic Duoneb)
Azelastine/Fluticasone (Dymista)
Azelastine (generic Astelin/generic Astepro)
Budesonide/Formoterol (Symbicort)
Cromolyn Sodium Ampul (generic Intal)
Dornase Alfa Soln (Pulmozyme)*
Fluticasone (Flovent HFA, Flovent Diskus)
Fluticasone/Salmeterol Disk (Advair Diskus/Advair HFA)
Fluticasone/Vilanterol (Breo Ellipta)
Iloprost (Ventavis)*
Ipratropium
(generic Atrovent NS/Atrovent HFA)
Mometasone/Formoterol (Dulera)
Montelukast (generic Singulair)
Roflumilast (Daliresp)
Tiotropium (Spiriva/Spiriva Respimat/Stiolto Respimat)*
Umeclidinium/Vilanterol (Anoro Ellipta)

MISCELLANEOUS UROLOGICALS

Alfuzosin (generic Uroxatral)
Alprostadil (Muse/Caverject)*
Bethanechol (generic Urecholine)
Desmopressin (generic DDAVP Soln/DDAVP Tab)
Darifenacin ER (generic Enablex)
Finasteride (generic Proscar)
Flavoxate (generic Urispas)
Mirabegron (Myrbetriq)
Pentosan Polysulfate Na (Elmiron)
Sildenafil (Viagra)*
Solifenacin (Vesicare)
Tadalafil (Cialis)*
Tolterodine (generic Detrol, generic Detrol LA)
Trospium (generic Sanctura XR)

MISCELLANEOUS AGENTS

Algalsidase Beta (Fabrazyme)*
Algucosidase Alpha (Myozyme)*
Calcium Acetate (Phoslo Cap)
Cevimeline HCL (generic Evoxac)
Cinacalcet HCL (Sensipar)*
Cyanocobalamin (Nascobal)*
Deferasirox (Exjade)*
Disulfiram (generic Antabuse)
Galsulfase (Naglazyme)*
Lanthanum Carbonate (Fosrenol)
Laronidase (Aldurazyme)*
Midodrine HCl (generic ProAmatine)
Nitisinone (Orfadin)*
Palivizumab (Synagis)*
Phytonadione (Mephyton)
Riluzole (generic Rilutek)*
Sevelamer Carbonate (Renvela)*
Varenicline (Chantix)*

*** May be subject to Prior Authorization Requirements and/or Quantity Limitations as determined by your plan parameters.**

Northern California Tile Industry Trust Funds

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

Dental Plan Options

The NCTI Trust Funds also offer dental coverage. You may choose any dentist when you need care. If you use an Aetna Dental PPO Provider, your costs will be lower because Aetna PPO Network dentists have agreed not to charge over a certain amount for different procedures.

Active Participants

After the annual deductible, the plan pays 70% of the cost of covered dental services. The calendar year maximum benefits paid are $2,000 per person. For orthodontia services (braces), the plan pays 70% up to the lifetime maximum of $2,000 per person.

Dental	Self-Funded Dental Plan
Network: Aetna PPO	You may visit any provider, but there are cost advantages to using an Aetna PPO provider.
Deductible- per calendar year	$50 annual per person/ $150 per family
Coinsurance	Class A Services 80% Class B Services 75%
Maximum Benefits Paid per Calendar Year	$2,000 per person
Orthodontia	70% coinsurance; $2,000 lifetime maximum

Retired Participants

After the annual deductible, the plan pays 80% of the cost of covered Class A services and 50% of the cost of covered Class B services. Class A services include routine dental check-ups only. Class B services include all other covered dental expenses. The calendar year maximum benefits paid are $2,000 per person.

Dental	Self-Funded Dental Plan
Network	You may visit any provider.
Deductible	$50 annual per person
Coinsurance	Class A Services 80% Class B Services 50%
Maximum Benefits Paid per Calendar Year	$2,000 per person

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

This Page Intentionally Left Blank

Northern California Tile Industry Trust Funds

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

CHIROPRACTIC BENEFIT

If you are enrolled in the self-funded PPO Plan, chiropractic procedures are covered, after the deductible is satisfied, at 80% for a PPO provider or 60% for a non-PPO provider, up to $1,000 per calendar year.

If you and your dependents are covered under the Kaiser HMO plan, which does not provide chiropractic benefits, the self-funded PPO Plan pays 80% of the charges for chiropractic care, up to $1,000 per year per person.

Kaiser participants are instructed to have their chiro provider file the claim with us by mail or fax or they can submit the bill/receipt for reimbursement at the address or fax number provided below.

ALCOHOL AND DRUG DEPENDENCY TREATMENT THROUGH BEAT IT!

Benefits for alcohol and drug dependency detoxification and rehabilitation are provided only when treatment is pre-authorized through Beat It!. These benefits are provided to bargaining unit employees, non-bargaining unit employees and individual employers, and the eligible dependents of those participants.

The following limitations apply to the benefits the self-funded PPO Plan will pay, and the patient is responsible for all charges not paid by the Plan. Different coverages and limitations apply if you are enrolled in an HMO option.

Inpatient Benefits for Rehabilitation After Detoxification
First confinement, without prior outpatient treatment under the Beat It! program:

Employee: …….100% of contracted rate

Other Inpatient Benefits:
When you use a PPO Provider ……90%
When you use a Non-PPO Provider…… 70%

Outpatient Benefits: (other than office visits)
When you use a PPO Provider…… 90%
When you use a Non-PPO Provider……..70%

Outpatient Benefits: (office visits)
When you use a PPO Provider……$10 copay
When you use a Non-PPO Provider……$20 copay

Submit chiropractic claims to:
Northern California Tile Industry
P.O. Box 1618
San Ramon, CA 94583
Fax# 925-297-6655

Contact BeatIt!:
www.beatitap.com
Phone# 408-436-2392
Fax# 408-436-2396

This Page Intentionally Left Blank

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

June 2024

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. 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.*

3. 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.*

4. 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.

5. 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.

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

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

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

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

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

11. 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.

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

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

14. For organ, eye or tissue donation purposes.

15. To comply with workers' compensation laws.

16. 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.

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

18. 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.

E. 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.

III. 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 SEPTEMBER 23, 2013.

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

This Page Intentionally Left Blank

Northern California Tile Industry Trust Funds

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

Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you have recently become covered under the Northern California Tile Industry Health and Welfare Plan ("The Fund"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Fund Office.

The Plan administrator is BeneSys Administrators (the "Fund Office") located at P.O. Box 1607, San Ramon, CA 94583. You can call the office at 925-208-9995 or 888-208-0250. The Plan administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You may send written notice of the event to: Northern California Tile Industry Health and Welfare Plan, P.O. Box 1607, San Ramon, CA 94583, or you can report a qualifying event by calling the Fund Office at 925-208-9995 or 888-208-0250 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation to the Fund Office at: P.O. Box 1607, San Ramon, CA 94583.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both) your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent along with a copy of the Social Security Administration's determination to the Northern California Tile Industry Health and Welfare Plan, P.O. Box 1607, San Ramon, CA 94583.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Northern California Tile Industry Health and Welfare Plan, P.O. Box 1607, San Ramon, CA 94583, or you can report a qualifying event by calling the Fund Office at 925-208-9995 or 888-208-0250 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation, or Medicare Card to the Fund Office at: P.O. Box 1607, San Ramon, CA 94583.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Fund Office by calling 925-208-9995, or 888-208-0250. Written correspondence should be sent to: Northern California Tile Industry Health and Welfare Plan, P.O. Box 1607, San Ramon, CA 94583. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

This Page Intentionally Left Blank

Northern California Tile Industry Trust Funds

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

NORTHERN CALIFONRIA TILE INDUSTRY
HEALTH AND WELFARE TRUST FUND
June 2024
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 January 31, 2014. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	

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

ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	**MONTANA** – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

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

Northern California Tile Industry Trust Funds

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

June 2024

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