



B.A.C. 3 Trust Funds

B.A.C. Local No. 3 Pension Plan
B.A.C. Local No. 3 Defined Contribution Pension Plan
B.A.C. Local No. 3 Health & Welfare Trust Fund
B.A.C. Local No. 3 Vacation Trust Fund

June 2026

MEMORANDUM TO: Kaiser Permanente Senior Advantage Retired Participants of the
B.A.C. Local No. 3 Health & Welfare Plan

FROM: Administration Office

SUBJECT: Summary of Benefits and Coverages – Kaiser Permanente Senior Advantage
Consolidated Beneficiary Designation Forms
Privacy Practices Notice
Notification of Women’s Health and Cancer Rights Act of 1998
Children’s Health Insurance Program (CHIP) Notice
Medicare Part D Notice

Enclosed you will find the Kaiser Permanente Senior Advantage (KPSA) Summary of Benefits and Coverages effective July 1, 2026 through June 30, 2027.

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

A copy of the annual notices including the B.A.C. Local No. 3’s Privacy Practice Notice, Women’s Health and Cancer Rights Act of 1998 and Children’s Health Insurance Program notices are also included in this packet.

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

**Summary of Benefits Chart for
Kaiser Permanente Senior Advantage (HMO) with Part D (7/1/26—6/30/27)**

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:

For any one Member\$1,000 per calendar year

Plan Deductible **None**

Professional Services (Plan Provider office visits) **You Pay**

Most Primary Care Visits and most Non-Physician Specialist Visits	\$25 per visit
Most Physician Specialist Visits	\$25 per visit
Annual Wellness visit and the “Welcome to Medicare” preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	\$25 per visit
Urgent care consultations, evaluations, and treatment.....	\$25 per visit
Physical, occupational, and speech therapy	\$25 per visit

Outpatient Services **You Pay**

Outpatient surgery and certain other outpatient procedures.....	\$25 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	\$20 per visit

Hospital Inpatient Services **You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$100 per admission
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Emergency Services **You Pay**

Emergency department visits.....	\$50 per visit
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Ambulance Services **You Pay**

Ambulance Services	No charge
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Prescription Drug Coverage **You Pay**

This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.

Initial coverage stage —until you have spent \$2,100 in 2026. (If you spend \$2,100, you move on to the catastrophic coverage stage).....	Generic drugs: \$10 for up to a 100-day supply Brand-name drugs: \$15 for up to a 100-day supply
Catastrophic coverage stage	No charge

Durable Medical Equipment (DME) **You Pay**

Covered durable medical equipment for home use	No charge
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Mental Health Services **You Pay**

Inpatient psychiatric hospitalization	\$100 per admission
Individual outpatient mental health evaluation and treatment.....	\$25 per visit

continued

Mental Health Services	You Pay
Group outpatient mental health treatment	\$12 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$100 per admission
Individual outpatient substance use disorder evaluation and treatment.....	\$25 per visit
Group outpatient substance use disorder treatment.....	\$5 per visit
Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge
Other	You Pay
Eyeglasses or contact lenses every 24 months.....	Amount in excess of \$175 Allowance
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
External prosthetic and orthotic devices	No charge
Fitness benefit – One Pass® (includes access to in-network gyms and one home fitness kit per calendar year).....	No charge

Summary of Benefits booklet

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.



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Beneficiary Election Form

Participant Name _____ SSN _____ DOB _____

Address _____

(if applicable) Spouse Name _____ SSN _____ DOB _____

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

- B.A.C. Local No. 3 Pension Plan (“Defined Benefit Plan”),
- B.A.C. Local No. 3 Defined Contribution Pension Plan (“Defined Contribution Plan”),
- Bricklayers Local No. 3 Vacation and Holiday Plan (“Vacation Plan”) and/or
- Life Insurance Benefits under the B.A.C. Local No. 3 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)):

- | | |
|---|---|
| <input type="checkbox"/> All Plans | <input type="checkbox"/> Defined Benefit Plan only |
| <input type="checkbox"/> Defined Contribution Plan only | <input type="checkbox"/> Health and Welfare Plan (Life Insurance Benefits) only |
| <input type="checkbox"/> 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

Contingent Beneficiary Designation

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

- | | |
|---|---|
| <input type="checkbox"/> All Plans | <input type="checkbox"/> Defined Benefit Plan only |
| <input type="checkbox"/> Defined Contribution Plan only | <input type="checkbox"/> Health and Welfare Plan (Life Insurance Benefits) only |
| <input type="checkbox"/> 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 for Defined Benefit Plan and Defined Contribution Plan: Any designation of your spouse for a pre-retirement death benefit will be automatically revoked upon the dissolution of your marriage. We recommend updating this designated beneficiary form after such an event occurs.

Note regarding Dissolution of Marriage for Health and Welfare Plan and Vacation Plan: Any designation of your spouse as your designated beneficiary will be automatically revoked upon the dissolution of your marriage. 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 (1) unmarried participants designating a beneficiary for a pre-retirement death benefit and (2) participants who have already retired under a Single Life Annuity with 36 months guarantee or the Life Annuity with 120 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, or if none, to your designated beneficiary.

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 also understand that I may not designate a person other than my spouse for the Defined Benefit Pension Plan and Defined Contribution Pension Plan death benefits unless my spouse consents to my designation.

Participant Signature _____

Date _____

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.
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State of California
County of _____)

On _____ before me, _____

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

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

WITNESS my hand and official seal.

Signature _____ (Seal)



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B.A.C. Local No. 3 Health and Welfare Plan

PRIVACY PRACTICES NOTICE

May 2026

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

Introduction. Health plans are required to protect the confidentiality of health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes the Brick and Allied Craftworkers Local No. 3 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 B.A.C. Local No. 3 Health and Welfare Plan is required by law to:
1. protect the privacy of your health information;
 2. provide you with this notice describing our legal duties to keep your health information private, as well as your rights to access your health information;
 3. notify affected individuals following a breach of unsecured protected health information; and
 4. follow the terms set out in this notice for as long as it is in effect.
- B. The Plan reserves the right to change the terms of this notice and make new provisions for the protection of your health information. However, if any change is made to the way your health information is used or disclosed, the Plan will notify you by sending you a new privacy practices notice to replace this one, or by sending you information about the change and how to obtain a copy of the Plan's new privacy practices notice.

II. USES AND DISCLOSURES

- A. The Plan is REQUIRED by law to disclose your health information, even without your written authorization, in the following circumstances:
1. To you, if you request it.
 2. When required by the Secretary of the Department of Health and Human Services to determine whether the Plan has adequately protected the privacy of your medical records.
- B. The Plan is ALLOWED by law to use or disclose your health information without your written authorization for the following purposes. The Plan is prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes.
1. **Treatment.** The Plan may disclose information to the doctors and hospitals that you have gone to for health care. *For example, if you are unable to provide your medical history to an*

emergency room doctor, the Plan may disclose to the doctor the types of prescription drugs you currently take.

2. For Substance Use and Disorder Treatment. The Plan may use or disclose your substance use and disorder treatment records or testimony relaying the content of such records to public health authorities, provided that the records disclosed are properly de-identified. However, the Plan may not use or disclose substance use and disorder treatment records or testimony relaying the content of such records in civil, criminal, administrative, and legislative proceedings against you, absent your written consent or a court order.
3. Payment for health care services. The Plan may use and disclose information so that claims for health care treatment, services and supplies you receive may be paid according to the Plan's terms. *For example, the Plan may need to know what treatment or supplies you received from your doctor, before it can reimburse your doctor for the services.*
4. Health care operations. The Plan may need to use some of your health information for its own internal purposes. *For example, the Plan may use some of your health information to conduct compliance audits, or to determine what coverage the Plan should provide.*
5. Reports to the Plan sponsor. The Plan may disclose information to the Board of Trustees so they can carry out their Plan-related administrative functions. The Plan's documents have been amended to ensure that the Board protects the privacy of such information.
6. Disclosures to the Plan's Business Associates. The Plan uses Business Associates to provide certain services to the Plan, such as administrative, legal, accounting, or health care services. The Plan may disclose health information to a Business Associate, where the Business Associate has agreed in writing to appropriately safeguard that information.
7. For public health activities and purposes, such as reporting communicable diseases to health authorities, as required by law.
8. To report child abuse, neglect or domestic violence, to the extent required by law.
9. To coroners, medical examiners and funeral directors, as necessary to carry out their duties.
10. For health oversight activities, such as audits or civil and criminal investigations of the Plan or health care providers.
11. In response to a court order, subpoena, discovery request, or other lawful process, if certain conditions for protecting your privacy are met.
12. For some law enforcement activities, such as complying with a law enforcement official's request for limited information to identify a suspect or missing person.
13. For research purposes, so long as specific conditions are met to guarantee your privacy.
14. To avert a serious threat to the health or safety of a person or of the public, consistent with applicable law.
15. For organ, eye or tissue donation purposes.
16. To comply with workers' compensation laws.

17. For the creation, renewal or replacement of a contract of health insurance or health benefits. If the contract is not created, renewed or replaced, your health information will not be used for any other purpose, except as required by law.
 18. For specialized government functions, such as military and veterans' activities, national security or intelligence, or correctional institutions.
 19. For other uses required by law.
- C. The Plan is ALLOWED to disclose your health information in the following circumstances ONLY if you have given the Plan a valid authorization:
1. Any use or disclosure of psychotherapy notes, except in certain situations as specified by law;
 2. For marketing by the Plan, except for face-to-face communications and gifts of nominal value. However, this Plan does no marketing; and
 3. For a sale of protected health information. However, this Plan does not sell protected health information.
- D. The Plan is ALLOWED to disclose your health information in the following circumstances ONLY if you have been given the opportunity to prohibit or restrict the use or disclosure, or if you are not present or are incapable of making medical decisions, and the Plan believes it is in your best interest:
1. For use in a directory of patients in a health care facility.
 2. To your family members, friends or other person designated by you, if they are participating in your treatment or making decisions with you or on your behalf.
 3. To notify your family members, personal representative or another person responsible for your care of your general condition, location or death.
- 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:

B.A.C. Local No. 3 Health and Welfare Plan
c/o BeneSys Administrators
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:

B.A.C. Local No. 3 Health and Welfare Plan
c/o BeneSys Administrators
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566
(925) 208-9995

VI. FEDERAL REGULATIONS

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

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

*This document has been uploaded and is available on the participant website at:
www.BAC3-brickbenefits.org*



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May 2026

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

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

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

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

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

NOTICE OF AVAILABILITY OF PLAN'S NOTICE OF PRIVACY PRACTICES

The B.A.C. Local No. 3 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:

Bricklayers Trust Funds
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.BAC3-brickbenefits.org*



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BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 3 HEALTH AND WELFARE TRUST FUND

May 2026

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	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants	Website: https://www.flmedicaidtprecovery.com/

7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 ♦ P.O. Box 1607 ♦ San Ramon, California 94583

Phone 925.208.9995 ♦ Toll Free 888.208.0250 ♦ Facsimile 925.362.8564

♦ www.BAC3-brickbenefits.org ♦ staff@BAC3-brickbenefits.org

Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	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
MAINE – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
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.hijosaludablesoregon.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	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability

Phone: 1-888-549-0820	
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.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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www.BAC3-brickbenefits.org*



B.A.C. Trust Funds

B.A.C. Local No. 3 Pension Plan
B.A.C. Local No. 3 Defined Contribution Pension Plan
B.A.C. Local No. 3 Health & Welfare Trust Fund
B.A.C. Local No. 3 Vacation Trust Fund

Important Notice from B.A.C. Local No. 3 Health and Welfare Plan About Your Prescription Drug Coverage and Medicare

Medicare Part D plans are available to every person who is eligible for Medicare. All such plans will provide at least a standard level of coverage set by Medicare and some plans may offer more coverage for a higher monthly premium. **Note that the Medicare Part D prescription drug program is NOT a benefit provided through the B.A.C. Local No. 3 Health and Welfare Plan ("Plan").** It is provided through Medicare and is marketed by various Medicare-approved "Prescription Drug Providers" (PDPs). If you are eligible for Medicare, you will have a chance to enroll in a Medicare-approved Part D plan from October 15th through December 7th of each year. If you ever lose your current Plan prescription drug coverage, through no fault of your own, you will then be eligible for a two-month special enrollment period to enroll in a Part D plan.

This notice is to inform you that your current prescription drug benefit program through the B.A.C. Local No. 3 Health and Welfare Plan provides "creditable coverage," as defined below. It also includes answers to questions you may have regarding your current prescription drug program and how it relates to Medicare Part D coverage.

2027 CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

The B.A.C. Local No. 3 Health and Welfare Plan hereby certifies that the prescription drug coverage it provides to Medicare-eligibles is expected to pay out, on average for prescription drugs for all such participants, at least as much as the standard Medicare Part D prescription drug coverage would be expected to pay on average in calendar year 2027. It is therefore designated as providing 2026 "creditable coverage," meaning that any participant who later enrolls in a Part D plan will not be charged a late enrollment penalty for 2026.

This is your notice of creditable coverage. Be sure to read it carefully and keep it in a safe place where you can find it. If you lose this notice and need another copy, please call the Plan's Administrator at (925) 208-9995, or request a copy in writing from BeneSys Administrators, 7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566. Updated versions of this notice will be sent annually, and you will be informed if the Plan ever loses its creditable coverage status.

FREQUENTLY ASKED QUESTIONS

(1) *If I am a retired Trust participant with Kaiser Senior Advantage, do I need to do anything now?*

No, if you stay with Kaiser or UnitedHealthcare then you have the Part D plan provided by that HMO. You cannot be enrolled in more than one Part D plan at a time, so if you attempt to sign up with another Part D provider you risk being disenrolled from your HMO medical and drug coverage. Call your HMO if you have any questions.

(2) *If I am an active Trust participant, or a retired participant not with Kaiser Senior Advantage, do I need to do anything now?*

No, you don't need to do anything.

When you first become eligible for Medicare¹, you will have the option to independently enroll in a Medicare Part D prescription drug plan. However, ***by independently enrolling in a Part D plan you will permanently lose your current prescription drug coverage under the B.A.C. Local No. 3 Health and Welfare Plan and you will not be reimbursed for your Part D premiums.*** As mentioned above, the standard Part D benefit is not as good as the Plan's own prescription drug program (as described in your Plan booklet).

You should compare your current prescription drug program, including which drugs are covered, with the benefits and costs of the Medicare Part D plans available in your area. To view the official summary of approved Medicare Part D plans in any U.S. state, visit <https://www.medicare.gov/find-a-plan/questions/home.aspx>. Note that a Part D plan might not include your regular prescription drugs on its formulary. The Plan cannot provide you with a complete comparison of available Part D plans, but we urge you to carefully review any descriptions you may obtain.

(3) *So why do I need to keep my notice of creditable coverage?*

In case you ever drop or lose your Plan coverage, or in the unlikely event that Plan coverage becomes non-creditable, having this notice will allow you to immediately enroll in a Part D plan without having to pay a late enrollment penalty. Specifically, if you try to enroll after your initial eligibility period, you will be charged a permanent Part D premium surcharge of 1% for every month since your initial Medicare eligibility for which you cannot show that you had creditable coverage (if such non-creditable period exceeds 62 days). Also note that you may have to wait for the next regular annual Part D enrollment period, which will be October 15th through December 7th for coverage in the following calendar year.

(4) *How can I get more information on Medicare Part D?*

More detail will be in the handbook "Medicare & You" that will be mailed to you by Medicare in October of each year. You may also be contacted directly by Medicare-approved Part D providers. At any time you can visit <http://www.medicare.gov/> or call 1-800-MEDICAR (1-800-633-4227). TTY users should call 1-877-486-2048.

¹ Your Medicare Initial Enrollment Period will be the month in which you become age 65, plus the preceding three months and the succeeding three months.

7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 ♦ P.O. Box 1607 ♦ San Ramon, California 94583

Phone 925.208.9995 ♦ Toll Free 888.208.0250 ♦ Facsimile 925.362.8564

♦ www.BAC3-brickbenefits.org ♦ staff@BAC3-brickbenefits.org

Every state has a Health Insurance Assistance Program to help Medicare beneficiaries and their families with their health insurance choices and with problems that might arise. In California it is called the "Health Insurance Counseling and Advocacy Program" (HICAP) and can be reached (by non-cell phones only) at 1-800-434-0222. Further assistance is available from the California Senior Information line (also by non-cell phones only) at 1-800-510-2020. Contact information for similar programs in other states will be listed in your "Medicare & You" handbook.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration website at <http://www.socialsecurity.gov/> or call them at 1-800-772-1213. TTY users should call 1-800-325-0778.

Be sure to keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium.

Date: May 2026
Plan Sponsor: B.A.C. Local No. 3 Health and Welfare Plan
Administrator: BeneSys Administrators
Address: 7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566
Telephone: (925) 208-9995

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