Bricklayers and Allied Craftworkers
Local No. 3 Health & Welfare Plan
P.O. Box 1607
San Ramon, CA 94583
(925) 208-9995 (888) 208-0250
Website: www.bac3-brickbenefits.org

Enhanced Member Benefit Website
www.bac3-brickbenefits.org

Dear Member:

The Trustees of the Bricklayers and Allied Craftworkers Local No. 3 Health & Welfare Plan are pleased to announce a new enhanced member benefit website, www.bac3-brickbenefits.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!

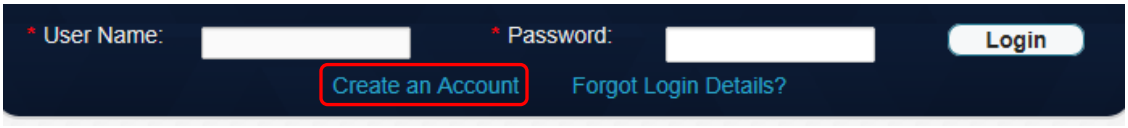
Board of Trustees,

Bricklayers and Allied Craftworkers Local No. 3 Health & Welfare Plan

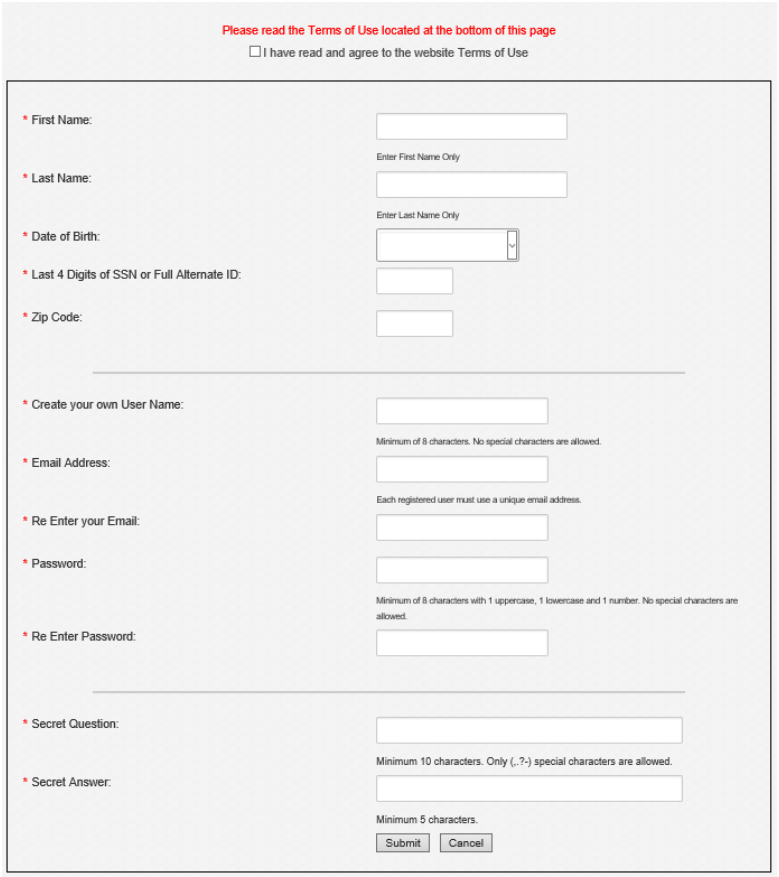
HOW TO REGISTER ON THE WEBSITE

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

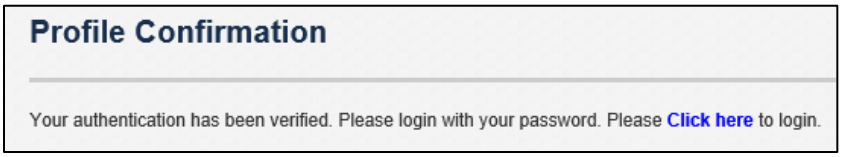
1) From your computer or mobile device, connect to the website listed on the front page of this letter.
2) Locate the Login box in the upper right-hand corner of the screen.
3) Click on "Create an Account" to get started.



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.



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

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. **It is very important that you and your spouse read the information regarding your rights to possibly continuing 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.**
Enrollment Form	This is required for all 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.
Grandfathered Health Plan Notice	Please read the explanation of the Grandfathered Status of the Plan.
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.**
Monthly Status Reports	These will be mailed to you around the second week of each month. This report 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.**
Notices of COBRA Continuation Coverage Rights	Please read this information. This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

-OVER-

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

Dental Plan	Dental Benefits are provided through Delta Dental 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 who are not enrolled in Kaiser. Please see the enclosed benefit summary sheet regarding VSP. Employees enrolled in Kaiser receive vision benefits through the Kaiser Program.
SAV-RX Prescription	Prescriptions are provided through SAV-RX. Please review the enclosed SAV-RX pamphlets and formulary list. **Additional pharmacy information may be obtained by visiting the SAV-RX website at www.savrx.com or by calling SAV-RX Customer Service at 1-866-233-4239.** **Note: If you choose Kaiser, 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.

PLEASE RETURN ALL FORMS TO:

BRICKLAYERS TRUST FUND
PO BOX 1607
SAN RAMON, CA 94583

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

Contenido de Paquete de Inscripción para Nuevos Miembros

Este paquete de inscripción se le envio ya que es usted elegible, o será elegible para cobertura médica. Es importante que lea cuidadosamente toda la información, para que usted tenga un mejor entendimiento de los beneficios que estan disponibles para usted. Asi mismo, es importante que llene correctamente y de manera elegible los formatos y los envíe a la oficina administrativa junto con los documentos requertidos. En caso de faltar información o de tener formas con información incompleta, el procesamiento de sus reclamos médicos y/o dentales podría retrasarse.

Adjunto encontrara:

Documento del Plan de Salud	Este libro contiene las reglas del Plan y la descripción de los beneficios disponibles para usted y para sus dependientes. Es muy importante que usted y su cónyuge lean la información con respecto a sus derechos de la posibilidad continuar su cobertura médica en caso de ser suspendida. Estas son conocidas "COBRA Rights" y son explicados en el Documento del Plan de Salud asi como en la notificación que se incluye en este paquete.
Formato de Inscripción	El Formato de Inscripción debe ser completado y enviadas a la dirección proporcionada. Lo antes possible. Esto evitara cualquier retraso en el procesamiento de de sus reclamos médicos y/o dentales.
Notificación del Plan de Antigüedad de Salud	Por favor lea la explicación del Estatus de Antigüedad (Grandfathered) del Plan.
Notificación de las Prácticas Privacidad (HIPAA) y	Por favor lea la información que se incluye en la notificación de Privacidad HIPAA, esta explica sus derechos, y como y cuando la información medica puede ser revelada. Effectivo Abril 2003, usted ya no puede recibir información de salud de los miembros de su familia por medio del teléfono solo podra recibir información de usted y de sus hijos menores de edad (menores de 18 años), al menos que tenga en el archivo de la oficina el formato the autorización firmado.
Formato de Autorización	Por favor complete y firme el formato adjunto de Autorización para Revelar Información Médica Protegida y enviela de regreso a la Oficina Administrativa.
Reportes de Estatus Mensual	Estos se le enviarán por correo la segunda semana de cada mes. Este reporte le proporcionará información muy importante con respecto a su elegibilidad para cobertura en Plan de Salud y tambien le proporcionará record de sus horas y contribuciones que le han sido reportadas por su empleador. Es importante que revise detenidamente este reporte cada mes.
Notificación de Derechos COBRA para Continuar su Cobertura	Por favor lea esta información. Esta notificación contiene información con respecto a sus derechos de continuar su cobertura COBRA, la cual es una extensión temporal de su cobertura bajo el Plan.

-SIGUIENTE PÁGINA-

Plan Dental	Los Beneficios Dentales se proveen por medio Delta Dental Plan. Por favor revise su Resumen de la Descripción del Plan para información de beneficios de cobertura disponibles y las exclusions que aplican al Plan.
Plan de Visión	Los Beneficios para Visión se proven por medio de Vision Service Plan ("VSP") a todos los empleados que no estan inscritos en Kaiser. Por favor vea la página adjunta del resumen de beneficios en relación a VSP. Empleados inscritos en Kaiser reciben sus beneficios de vision por medio del Programa Kaiser.
Medicamentos SAV-RX	La cobertura de medicamentos se prove por medio de SAV-RX. Por favor revise los folletos de SAV-RX adjuntos y la lista del formulario. **Información adicional de farmacias puede ser obtenida visitando la página web de SAV-RX en www.savrx.com or llamando a la línea de servicio al Cliente de SAV-RX al 1-866-233-4239.** **Nota: Si usted elige Kaiser, su cobertura para medicamentos se proveera por medio de Kaiser.**
Tarjetas de Identificación	Sus tarjetas de Identificación se ordenaran al momento de recibir el Formato de Inscripción completado por los aplicantes.

POR FAVOR ENVIE TODAS LAS FORMAS A:

BRICKLAYERS TRUST FUND
PO BOX 1607
SAN RAMON, CA 94583

*****USTED DEBE PROPORCIONAR COPIA DE SU ACTA DE MATRIMONIO PARA AGREGAR A SU CONYUGE Y ACTA DE NACIMIENTO(S) PARA AGREGAR A HIJO(S) DEPENDIENTE(S)*****

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

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. You must complete, sign/date, and return to the Trust Fund Office.
☐	**Coordination of Benefits Form**	This is required for all Participants. Please complete this form whether you, your spouse, or any of your dependents have/do not have other insurance benefits and return with your Enrollment Form to the Trust Fund Office.
☐	**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 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, California 94583
Phone 925.208.9995 ◆ Toll Free 888.208.0250 ◆ Facsimile 925.362.8564
◆ www.BAC3-brickbenefits.org ◆ staff@BAC3-brickbenefits.org

LISTA DE VERIFICACIÓN PARA NUEVOS MIEMBROS DE FORMATOS QUE DEBE REGRESAR A LA OFICINA ADMINISTRATIVA:

(Probablemente no sea necesario completar todas las formas de la lista, depende de la cobertura que usted elija. Si tiene preguntas con respecto a su inscripción por favor contacte a la Oficina Administrativa.)

☐	**Formato de Inscripción**	Es requerida para todos los Participantes.
☐	**Información de Otra Aseguranza**	Complete este formato si usted, su cónyuge, o cualquiera de sus dependientes tienen beneficios bajo otra aseguranza.
☐	**Autorización para Revelar Información Médica Protegida**	Es altamente recomendable que usted, su cónyuge y sus dependientes elegibles mayors de 18 años completen el formato de Autorización para Revelar Información Médica Protegida.
☐	**Formato para Designar Beneficiario**	Es altamente recomendable que usted complete el formato para Designar Beneficiario para asegurar que los beneficios de aseguranza de vida son pagados como usted lo desea..
☐	**Certificado de Matrimonio**	Si usted es casado, por favor envíe fotocopia de su certificado de matrimonio.
☐	**Declaración de Asociación Doméstica**	En caso de tenr una Asociación Domestica registrada, for favor envíe fotocopia de su Declaración de Asociación Doméstica.
☐	**Actas de Nacimiento**	Por favor envíe fotocopias de las actas de nacimiento de: Usted, su cónyuge/Pareja Doméstica; y de todos sus dependientes que desee inscribir en su Plan (incluyendo hijastros e hijos adoptivos).

B.A.C. Trust Funds

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B.A.C. Local No. 3 Vacation Trust Fund

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

ENROLLMENT FORM

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: Male____ Female ____

EMAIL:_____ PHONE NUMBER: (_____)_____

MEDICAL PLAN (CHOOSE ONE):	**DENTAL PLAN (CHOOSE ONE):**
☐ BLUE CROSS (INDEMNITY PLAN)	☐ DELTA DENTAL PPO
☐ KAISER PERMANENTE (Group# 7748-0000) ***If enrolling in Kaiser, you must also sign the Kaiser Arbitration Agreement (below).**	☐ DELTA CARE -DHMO

Medicare Claim Number: (including the letter(s) that follows the number)
(Applicable only when a member, a spouse, or a covered dependent is age 65 or older; or is on Medicare disability.)

Member #_____ **Spouse #**_____ **Dependent # and Name** _____

DEPENDENTS - (Including Spouse)

(ATTACH LEGAL DOCUMENTATION THAT APPLIES: birth certificate(s), marriage certificate, adoption papers, guardianship papers)

FULL LEGAL NAME	SOCIAL SECURITY NUMBER	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 for the Kaiser Permanente Plan **Date**

I agree to notify the Fund 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 stating false or misleading information or the omission of material information could be grounds for denial ofbenefits.

MEMBER SIGNATURE_____ **DATE:** _____

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

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Coordination of Benefits

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

Address: _____

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

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

A

MEMBER HEALTH COVERAGE INFORMATION

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

Name of Medical/Rx 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/Rx 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/Rx** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

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

2.) Dependent: _____

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

- Name of **Medical/Rx** 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/Rx** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical/Rx** 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/Rx** 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**.

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:

Brick and Allied Craft Workers Local No. 3 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.bac3-brickbenefits.org • staff@bac3-brickbenefits.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.

B.A.C. TRUST FUNDS
P O Box 1607 ♦ San Ramon, CA 94583
Telephone: (925) 208-9995 ♦ Fax: (925) 362-8564

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)):*

☐ 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

B.A.C. TRUST FUNDS
P O Box 1607 ♦ San Ramon, CA 94583
Telephone: (925) 208-9995 ♦ Fax: (925) 362-8564

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 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 _____

B.A.C. TRUST FUNDS
P O Box 1607 ♦ San Ramon, CA 94583
Telephone: (925) 208-9995 ♦ Fax: (925) 362-8564

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

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

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

Date: _____

ACKNOWLEDGMENT

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

State of California
County of _____)

On _____ before me, _____

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

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

WITNESS my hand and official seal.

Signature _____ (Seal)

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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, please visit our website at www.benesys.com . 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.benesys.com 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) Copayments for medical office visits and charges for dental and vision benefits and prescription drugs do not count towards the overall deductible.	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 services	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?	Copayments for office visits, chiropractic, prescription drugs, dental and vision benefits, premiums, balance-billed charges, and health care this plan doesn't cover.	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.	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?	No.	You can see the specialist you choose without a referral

[* For more information about limitations and exceptions, see the plan or policy document at [www.benesys.com].

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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copayment/visit	$20 copayment/visit	You will not pay more than $10 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR. Telehealth visits are also a covered benefit.
	Specialist visit	$20 copayment/visit	$40 copayment/visit	You will not pay more than $20 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Other practitioner office visit	20% coinsurance for chiropractic	40% coinsurance for chiropractic	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Limited to $1,000 annual maximum. Out-of-network provider coverage limited to UCR.
	Preventive care/screening/ immunization	$10 copayment for routine physical and Well Child visits. 20% coinsurance for Well Woman care. No charge for flu shot under Rx plan	Annual routine physical not covered. $20 copayment for Well Child visits. 40% coinsurance for Well Woman care.	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. Routine and preventive adult immunizations are covered at 80% in-network and 60% out-of-network.

[* For more information about limitations and exceptions, see the plan or policy document at [www.benesys.com].

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.ssatpa.com**	Generic drugs	No charge	Not covered	Covers up to 30-day supply (retail subscription); 31-90 day supply (mail order prescription). 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.
	Formulary brand drugs	$10 copayment retail $20 copayment mail order	Not covered	
	All other drugs	$40 copayment retail $80 copayment mail order	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	You will have to pay 40% coinsurance 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. Out-of-network provider coverage limited to UCR.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required for inpatient surgery. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$10 copayment per visit	$20 copayment per visit	You will not pay more than $10 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Utilization review required or benefits are not payable. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Substance use disorder outpatient services	$10 copayment per visit	$20 copayment per visit	You will not pay more than $10 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Utilization review required or benefits are not payable. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Prenatal and postnatal care	20% coinsurance	40% coinsurance	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required. Maximum 100 visits per calendar year. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Rehabilitation services	20% coinsurance	40% coinsurance	You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care / inpatient hospice	20% coinsurance	40% coinsurance	Preauthorization is required. Maximum benefit of 60 days during any one period of confinement. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Durable medical equipment (rental)	20% coinsurance	40% coinsurance	Rental cost in excess of purchase price is not covered. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.
	Outpatient Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. Maximum 100 visits per calendar year. You will not pay more than 20% coinsurance for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Eye exam	$10 copayment	Covered up to $45 max	Coverage limited to one per year.
	Glasses	$10 copayment per pair; $120 frame allowance	Lenses covered up to $85 depending on type; $47 frame allowance	Coverage limited to one per year for lenses. Coverage limited to one per two years for frames.
	Dental check-up	For Delta PPO enrollees: no charge after $25 deductible For Delta HMO employees: no charge	For Delta PPO enrollees: no charge after $25 deductible For Delta HMO employees: no charge	For Delta PPO enrollees: You will not pay more than $25 for non-emergency services provided by a non-PPO provider at a PPO facility. If you consent to the non-PPO billing rates, you are responsible for the difference. Out-of-network provider coverage limited to UCR. For Delta HMO enrollees: Coverage limited to two per year.

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 as the result of an injury, for the correction of a congenital defect of a dependent child, or for replacement of diseased tissue surgically removed
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Treatment that is not medically necessary
- 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
- Chantix and other smoking cessation products
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Laser Eye Surgery
- Podiatry Benefits
- 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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: 1-800-432-6636 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 [1-800-432-6636].

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-800-432-6636].

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[1-800-432-6636].

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-800-432-6636].

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

[* For more information about limitations and exceptions, see the plan or policy document at [www.benesys.com].

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	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$250
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,310**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*	$250
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$970**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$250
Copayments	$60
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$710**

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

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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.
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	$25 / visit	Not Covered	None
	Specialist visit	$25 / 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)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRI's)	No Charge	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)	$15 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines.
	Non-preferred brand drugs (Tier 2)	$15 / 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)	$15 / 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)	$25 / 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	$50 / visit	$50 / visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$25 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: $25 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 / 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	$25 / individual visit. No Charge for other outpatient services	Not Covered	Mental / Behavioral Health: $12 / group visit; Substance Abuse: $5 / group visit.
	Inpatient services	$100 / 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	$100 / 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: $100 / admission; Outpatient: $25 / visit	Not Covered	None
	Habilitation services	$25 / 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	No Charge	Not Covered	Up to $200 frames & lenses / 24 months, or up to $200 contact lenses (instead of glasses) / 12 months.
	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.)

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

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

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

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

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

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

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

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

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

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

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

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** **$25**
- **Hospital (facility) copayment** **$100**
- **Other (blood work) copayment** **$0**

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	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$150**

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** **$25**
- **Hospital (facility) copayment** **$100**
- **Other (blood work) copayment** **$0**

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	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$600**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$100**
- **Other (x-ray) copayment** **$0**

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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente[1] 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, 24 hours a day, 7 days a week (closed holidays). The call is free:

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **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. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Medi-Cal members may call **1-855-839-7613** (TTY **711**). All other members may call **1-800-464-4000** (TTY **711**). Help is available 24 hours a day, 7 days a week (closed holidays)
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.

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[1] Kaiser Permanente is inclusive of Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, and the Southern California Medical Group

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

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

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

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

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

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:
  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:
  https://www.hhs.gov/ocr/complaints/index.html
- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, or materials translated into your language, or in alternative formats. You can also request auxiliary aids and devices at our facilities. Call our Member Service Contact Center for help, 24 hours a day, 7 days a week (closed holidays).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. اتصل مع مركز اتصال خدمة الأعضاء لدينا، على مدار 24 ساعة في اليوم و 7أيام في الأسبوع (العطلات مغلق).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- جميع الآخرين: **1-800-464-4000** (TTY **711**)

Armenian: Ձեզ կարող է անվճար լեզվական աջակցություն տրամադրվել օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման կապի կենտրոն օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է):

- Medi-Cal՝ **1-855-839-7613** (TTY **711**)
- Այլ՝ **1-800-464-4000** (TTY **711**)

Chinese: 我们每周 7 天，每天 24 小时免费提供语言帮助。您可以要求提供口译员、或将材料翻译为您所用语言或其他格式。您还可以在我们的设施中要求使用辅助工具和设备。请打电话给我们的会员服务联络中心，服务时间为每周 7 天，每天 24 小时（节假日除外）。

- 所有会员：**1-800-757-7585** (TTY **711**)

Farsi: خدمات زبانی در 24 ساعت شبانه‌روز و 7 روز هفته به‌صورت رایگان در اختیار شماست. می‌توانید خدمات مترجم شفاهی، یا ترجمه مدارک به زبان خود یا به فرمت‌های دیگر را درخواست کنید. همچنین می‌توانید دستگاه‌ها و کمک‌های دیگر را در مراکز ما درخواست نمایید. برای دریافت کمک، در 24 ساعت شبانه‌روز و 7 روز هفته (به‌جز تعطیلات) با مرکز تماس خدمات اعضای ما تماس بگیرید.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- سایر: **1-800-464-4000** (TTY **711**)

Hindi: बिना किसी लागत के भाषा सहायता, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप दुभाषिये की सेवाओं के लिए, या बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों का अनुरोध कर सकते हैं। आप हमारे सुविधा-

स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं।सहायता के लिए हमारी सदस्य सेवाओं के सम्पर्क केंद्र को, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- बाकी दूसरे: **1-800-464-4000** (TTY **711**)

Hmong: Muaj kev pab txhais lus pub dawb rau koj, 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Hu rau peb Qhov Chaw Pab Cov Tswv Cuab 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg (cov hnub caiv kaw).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Dua lwm cov: **1-800-464-4000** (TTY **711**)

Japanese: 多言語による情報支援を無料で 24 時間年中無休でご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは別の形式による資料もご所望いただけます。また、当施設における補助的な支援や機器についてもご所望いただけます。お気軽にご連絡ください（祝祭日を除き 24 時間週 7 日）。

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- その他のご連絡先: **1-800-464-4000** (TTY **711**)

Khmer (Cambodian): ជំនួយភាសា គឺឥតគិតថ្លៃដល់អ្នកទេ។ យើង 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំស្រាវអ្នកបកប្រែ បងាកសារដែលបានបកប្រែ ជាភាសាខ្មែរ ឬទម្រង់ជំនួសផ្សេងទៀត។ អ្នកក៏អាចស្នើសុំជំនួយបរិក្ខារជំនួយ ទីនាកទន្ទឹងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ ទូរសព្ទទៅមជ្ឈមណ្ឌល ទីនាកទន្ទឹងសេវាកម្មសមាជិករបស់យើងសម្រាប់ជំនួយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (ថ្ងៃឈប់សម្រាកបុទ)។

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ផ្សេងទៀតទាំងអស់: **1-800-464-4000** (TTY **711**)

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스 또는 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 저희 가입자 서비스 연락 센터에 주 7 일, 하루 24 시간(공휴일 휴무) 전화하셔서 도움을 받으십시오.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- 기타 모든 경우: **1-800-464-4000** (TTY **711**)

Laotian: ມີການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ. ທ່ານຍັງສາມາດຂໍບໍລິການຜູ້ແປພາສາ ຫຼື ເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໄດ້. ທ່ານຍັງສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ເຄື່ອງມືຢູ່ສະຖານບໍລິການຂອງພວກເຮົາໄດ້. ໂທຫາສູນຕິດຕໍ່ບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ (ປິດໃນວັນພັກ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ອື່ນໆທັງໝົດ: **1-800-464-4000** (TTY **711**)

Mien: Mbenc nzoih liouh wangv-henh tengx nzie faan waac bun muangx meih maiv cingv, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm leiz baaix mbenc maaih 7 hnoi. Meih se haih tov heuc tengx faan benx meih nyei waac bun muangx, a’fai zoux benx nyungc horngh jaa-sic zoux benx meih nyei waac. Meih corc haih tov tengx nyungc horngh jaa-dorngx aengx caux jaa-sic

nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Beiv hnangv qiemx zuqc longc mienh nzie weih nor douc waac lorx taux yie mbuo ziux goux baengc mienh nyei gorn zangc, yietc hnoi tengx duqv 24 norm ziangh hoc, yietc norm leiz baaix tengx duqv 7 hnoi (simv cuotv gingc nyei hnoi se guon oc).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yietc zungv da'nyeic deix: **1-800-464-4000** (TTY **711**)

Navajo: Díí hózhó nízhoní bee hane' dóó jíik'ah jóóní doonílwo'. Ndik'é yádi naaltsoos bee haz'áanii bee hane' dóó yádi nihookaa dóó nádááhágíí yádi nihookaa. Shí éí bee háídínii bibee' haz'áanii dóó bee t'ah kodí bízíkinii wo'da'gi doolyé. Ahéhee' bik'ehgo nohólǫǫn'ígíí, 24 t'áádawołíí, 7 t'áádawołíígo (t'áadoo t'áálwo').

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yadilzingo biłk'ehgo bee: **1-800-464-4000** (TTY **711**)

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਲਈ, ਜਾਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਮਦਦ ਲਈ ਸਾਡੀ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਕਾੱਲ ਕਰੋ।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ਹੋਰ ਸਾਰੇ: **1-800-464-4000** (TTY **711**)

Russian: Языковая помощь доступна для вас бесплатно круглосуточно, ежедневно. Вы можете запросить услуги переводчика или материалы, переведенные на ваш язык или в альтернативные форматы. Вы также можете заказать вспомогательные средства и приспособления. Для получения помощи позвоните в наш центр обслуживания участников ежедневно, круглосуточно (кроме праздничных дней).

- Medi-Cal: **1-855-839-7613** (линия TTY **711**)
- Все остальные: **1-800-464-4000** (линия TTY **711**)

Spanish: Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Usted puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Llame a nuestra Central de Llamadas de Servicio a los Miembros para recibir ayuda 24 horas al día, 7 días a la semana (excepto los días festivos).

- Para todos los demás: **1-800-788-0616** (TTY **711**)

Tagalog: May magagamit na tulong sa wika nang wala kayong babayaran, 24 na oras sa isang araw, 7 araw sa isang linggo. Maaari kayong humiling ng mga serbisyo ng interpreter, o mga babasahin na isinalin sa inyong wika o sa mga alternatibong format. Maaari rin kayong humiling ng mga pantulong na gamit at device sa aming mga pasilidad. Tawagan ang aming Center sa Pakikipag-ugnayan ng Serbisyo sa Miyembro para sa tulong, 24 na oras sa isang araw, 7 araw sa isang linggo (sarado sa mga pista opisyal).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Lahat ng iba pa: **1-800-464-4000** (TTY **711**)

Thai: มีบริการช่วยเหลือด้านภาษาตลอด 24 ชั่วโมงทุกวันโดยไม่มีค่าใช้จ่าย โดยคุณสามารถขอใช้บริการล่าม บริการแปลเอกสารเป็นภาษาของคุณหรือในรูปแบบอื่นๆ ได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการของเราโดยโทรหาเราที่ศูนย์ติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือตลอด 24 ชั่วโมงทุกวัน (ปิดทำการในช่วงวันหยุด)

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ที่อื่นๆทั้งหมด: **1-800-464-4000** (TTY **711**)

Ukranian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача або отримання матеріалів у перекладі мовою, якою володієте, чи в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Телефонуйте в наш контактний центр для обслуговування клієнтів цілодобово, 7 днів на тиждень (крім святкових днів).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Усі інші: **1-800-464-4000** (TTY **711**)

Vietnamese: Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, hoặc tài liệu được dịch ra ngôn ngữ của quý vị hoặc nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Gọi cho Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**)

A Look at Your VSP Vision Coverage

With VSP and BAC LOCAL 3 HEALTH AND WELFARE 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.

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

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

BAC LOCAL 3 HEALTH AND WELFARE TRUST FUND and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
07/01/2024

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
PRESCRIPTION GLASSES			
FRAME†	• $140 Featured Frame Brands allowance • $120 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 • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every 12 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings 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. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
	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.		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†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**.

Classification: Restricted

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24/7 access to doctors by phone or video.

Hable con un médico por teléfono o video las 24 horas del día, los 7 días de la semana.

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Coverage Effective Date: 03/01/2021

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& Eligible Dependents /
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SAMUEL SAMPLETON
1 SAMPLING ST
SAMPLEVILLE, AZ 29401

Made available by:

Welcome to Teladoc®. As a physician, providing patients with the highest quality healthcare has always been a priority for me. Now, as the Chief Medical Officer of Teladoc, my colleagues and I can bring that quality healthcare to you anytime, anywhere — at work, in the comfort of your home or while traveling.

As a new Teladoc member, you now have access to our national network of U.S. board-certified physicians, licensed in your state.

With an average of over 20 years of clinical experience, our doctors can diagnose, treat and prescribe medication for your non-emergency conditions. This includes treatments for the flu, sore throat, eye infections, bronchitis, and much more.

Whenever you need our care, we are available within minutes, by phone or video. We look forward to serving you.

Sincerely,

Lewis Levy, MD
Teladoc, **Chief Medical Officer**
30 Years of Experience

Bienvenido a Teladoc®. Como médico, proporcionar a los pacientes atención médica de la mejor calidad siempre ha sido una prioridad para mí. Ahora, como el Director Médico General de Teladoc, mis colegas y yo podemos brindarle dicha atención médica de calidad a usted en cualquier momento y en cualquier lugar: en el trabajo, en la comodidad de su hogar o mientras viaja.

Como nuevo miembro de Teladoc, a partir de este momento usted tiene acceso a nuestra red nacional de médicos certificados en los Estados Unidos, con licencia en su estado.

Con más de 20 años de experiencia clínica, nuestros médicos pueden diagnosticar, tratar y recetar medicamentos para aquellas afecciones que no sean de emergencia. Esto incluye tratamientos para la gripe, dolor de garganta, infecciones de oculares, bronquitis, y mucho más.

Estamos a su disposición en cuestión de minutos, siempre que necesite nuestra atención, por teléfono o video. Esperamos poder servirle.

Atentamente,

Lewis Levy, MD
Teladoc, **Director Médico General**
30 Años de Experiencia

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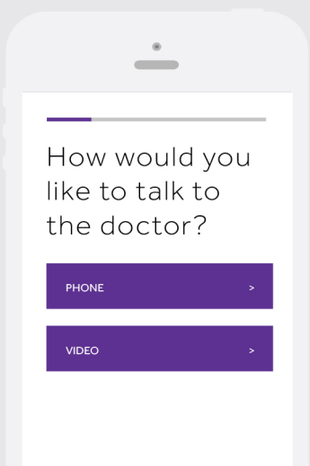
1 Get Started
Call, download the app or visit the URL above.

2 Set up
Enter your information and complete your medical history.

3 Request a Visit
A Teladoc doctor is now just a call or click away.



1 Comience
Llame, descargue la aplicación o visite la URL de arriba.

2 Preparar
Proporcione su información e historia clínica

3 Solicite una visita
Un médico de Teladoc está en este momento a solo una llamada o un clic de distancia

"The service is incredible! Being able to get a visit wherever you are and whenever you need it is beyond convenient. On top of that, ***the doctors always make me feel very confident in their diagnoses and recommendations****."*

"El servicio es increíble! Ser capaz de obtener una visita en cualquier lugar y siempre que lo necesite Está más allá conveniente. Además de eso, **los médicos siempre me hacen sentir muy confiado en sus diagnósticos y recomendaciones***."*

Sam Y. - *Teladoc Member Since / Miembro desde 2016*

Visit **www.teladoc.com/doctors** to discover how our doctors make the difference.
Visita **www.teladoc.com/doctors** para descubrir cómo nuestros médicos hacen la diferencia.

A few reasons why our 20+ million members trust us.
Algunas razones por las que nuestros 20+ millones de miembros confían en nosotros.

10 min
median response time

Tiempo de respuesta promedio de **10 minutos**

24/7
anytime, anywhere*

En cualquier momento, en cualquier lugar, **las 24 horas del día, los 7 días de la semana***

92%
of patient issues resolved after first visit

92% de los problemas del paciente se resolvieron después de la primera visita

95%
member satisfaction

Promedio de Satisfacción de Miembros del **95%**

Your Available Services / Sus Servicios Disponibles

General Medical / Medicina General | Available / Disponible 03/01/2021

- Board-certified doctors and pediatricians available 24/7/365
- Treat flu, allergies, sinus infection, rash, sore throat and more
- Médicos y pediatras certificados disponibles las 24 horas del día, los 7 días de la semana, los 365 días del año
- Trate gripe, alergias, sinusitis, erupción cutánea, dolor de garganta y mucho más

Family Physician
Médicos de Familia

FREE visits / Visitas **gratis**

Download the app / ¡Llame para empezar!

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*Teladoc is not available internationally. Teladoc no esta disponible internacionalmente.

Teladoc complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Para obtener ayuda en su idioma, llame sin costo alguno al número que aparece en su tarjeta de identificación. (TTY: 1-855-636-1578)
T'áá shí shizaad k'ehjí shíká a'doowoł nínízingo naaltsoos bee atah nílínígíí nanitinígíí béésh bee hane'é bikáá' áajį' hodíílnih. (TTY: 1-855-636-1578)

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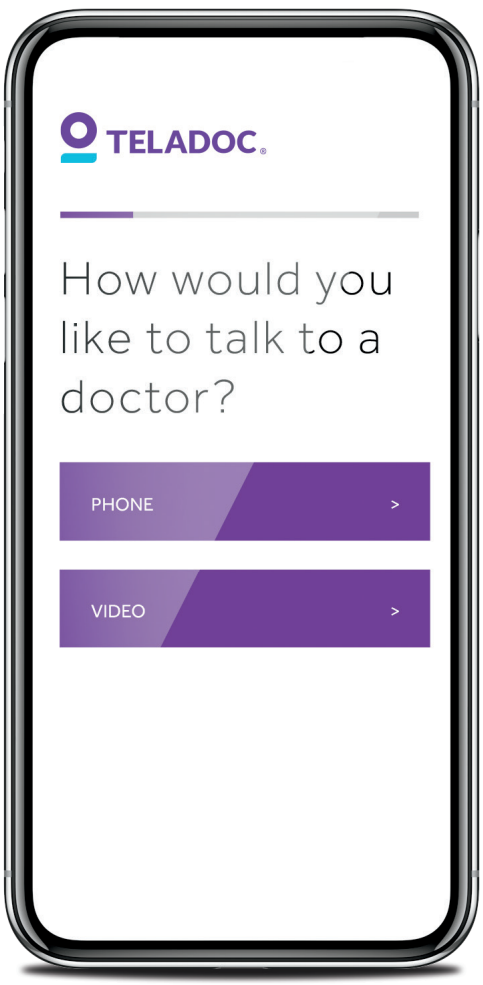
in 4 easy steps



Download the app to talk to a doctor anytime, anywhere by phone or video.

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1 Download the app
Search for "Teladoc" in the App Store or on Google Play.

2 Set up your account
Once you've downloaded the app, select "Set up your account."

3 Enter basic contact information
Provide some information about yourself to confirm your eligibility. We'll confirm we found your benefits and you'll continue creating your account.

4 Create your account
Enter your address and phone number, create a username and password, pick security questions, and agree to terms and conditions.

Download the app to talk to a doctor.

Download the app

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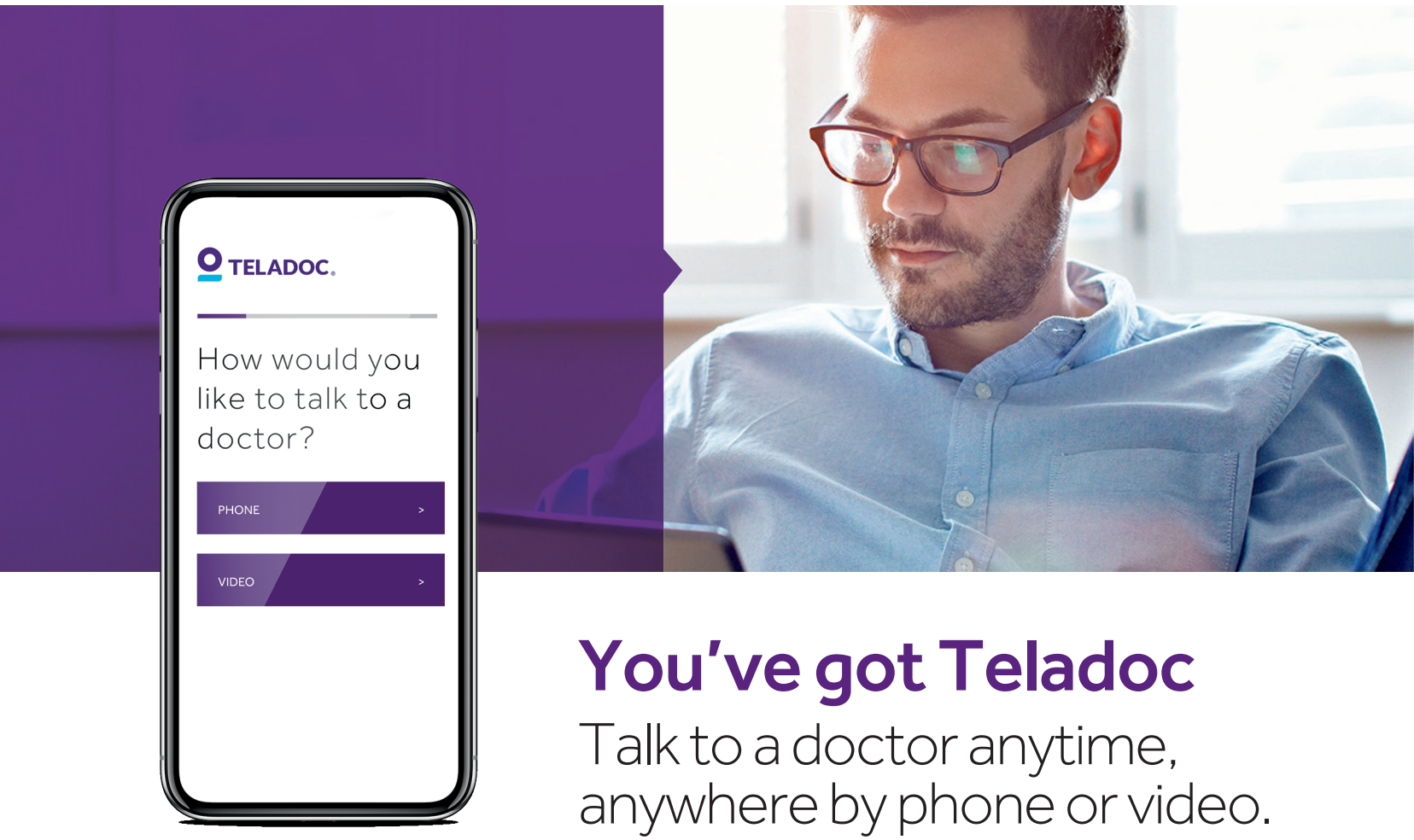


You've got Teladoc

Talk to a doctor anytime, anywhere by phone or video.

Set up your account today to talk to a U.S.-licensed physician for non-emergency medical conditions like the flu, sinus infections, bronchitis, and much more.

Create account

Use your phone, the app, or the website to create an account and complete your medical history

Talk to a doctor

Request a time and a Teladoc doctor will contact you

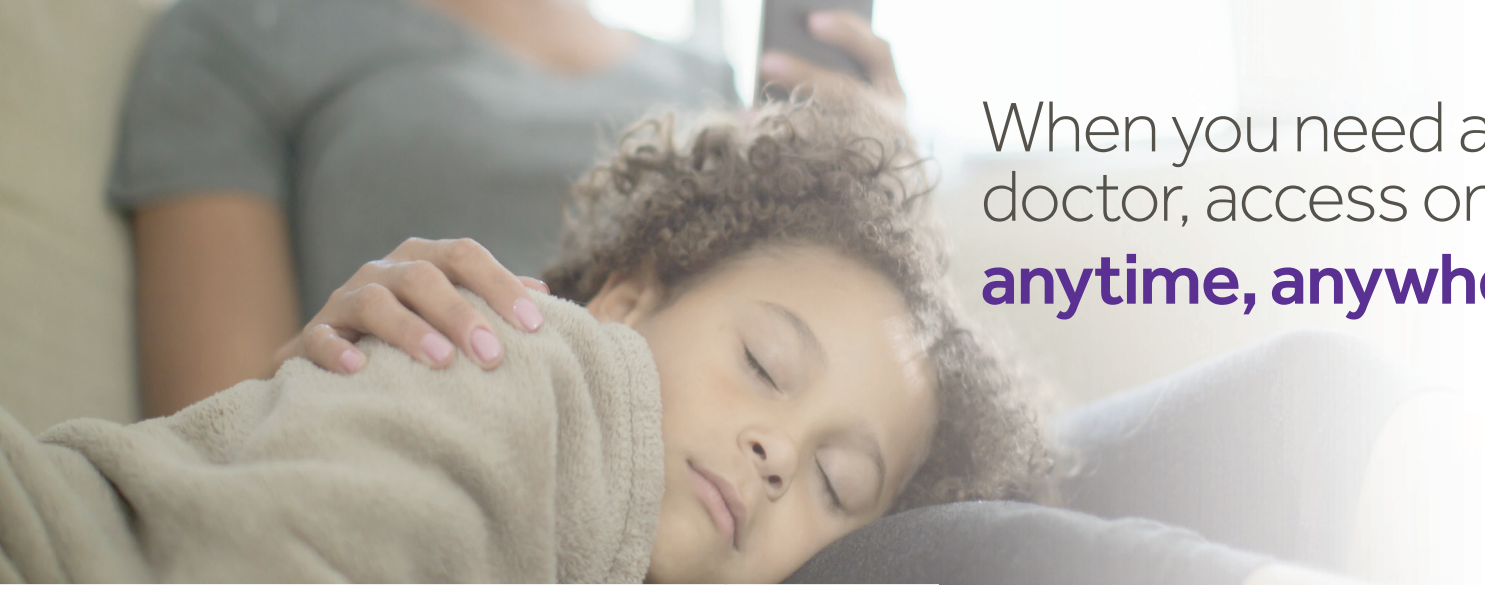
Feel better

The doctor will diagnose symptoms and send a prescription if necessary

Talk to a doctor

Call 1-800-TELADOC (835-2362) | Visit Teladoc.com

Download the app



When you need a doctor, access one **anytime, anywhere**

TELADOC.

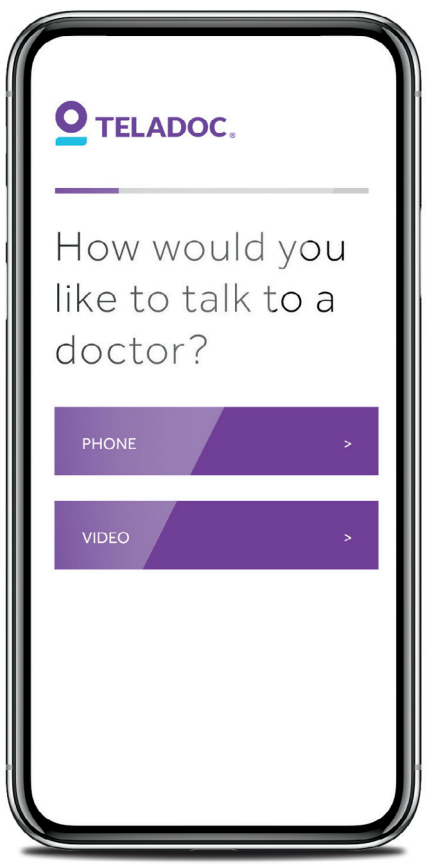
Skip the trip to the waiting room. With Teladoc, you can talk with a doctor by phone or app from wherever you are.

Know your care options:

Teladoc
For non-emergency conditions like the flu, allergies, infections, and much more. Our doctors can also prescribe medicine if necessary.

Family doctor
For annual exams and ongoing medical conditions needing regular monitoring.

Urgent care/ER
For severe conditions like chest pain, sprains, cuts, burns, or broken bones.



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DELTA DENTAL®

Your Smile, Your Choice

Delta Dental PPO™ & DeltaCare® USA

You can choose between two dental plans from Delta Dental. Either way, you'll get reliable dentist networks and affordable preventive care. Your options are:

Delta Dental PPO[1]

This preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere. Covered services are paid based on a percentage — if, for example, fillings are covered at 80%, you pay the remaining 20%. Get the most plan value by choosing a Delta Dental PPO dentist. PPO network dentists complete claim forms for you and can help advise you on questions regarding your share of the payment.

DeltaCare USA

Under this HMO-type plan, you'll have your choice of skilled primary care dentists from the DeltaCare USA network. Select a primary care dentist, who will then coordinate any needed referrals to a specialist.[2] Covered services provided by your DeltaCare USA dentist have preset copayments (dollar amounts), which are listed in your plan booklet. There are no maximums or deductibles.[3]

Turn the page for more details to help you choose the best plan for your needs.

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] In WY, you do not need to select a primary care dentist, but you must visit a network dentist to receive benefits. In the following states, you can maximize your savings when you visit a network dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

[3] Refer to your plan booklet for more information about covered services, deductibles and maximums.

Compare plan features

	Delta Dental PPO	DeltaCare USA
Can I go to any dentist?	You can visit any licensed dentist to receive coverage, but you'll save the most at an in-network dentist.	You must select a DeltaCare USA primary care dentist and visit this dentist to receive benefits.[2]
What procedures are covered?	Your plan covers a wide range of services, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, is offered at low or no cost.	Your plan covers over 300 procedures, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, has low or no copayments.
Are there deductibles and maximums?	Yes, most plans have an annual deductible and maximum.	No, there are no annual deductibles or maximums.[4]
Am I covered for treatment I began under a different employer-sponsored dental plan?	Coverage is provided only for treatment started and completed after your effective date. Orthodontic treatment may be an exception to this rule.	Coverage is provided only for treatment started and completed after your effective date.[5] Orthodontic treatment may be an exception to this rule.
What if I started orthodontic treatment under my previous dental plan?	Typically, Delta Dental pays the remaining benefit not paid by your prior dental plan.	You are responsible for the copayments and fees subject to the provisions of your prior dental plan.
What happens if I need to see a specialist?	You do not need a referral from your dentist.	Contact your DeltaCare USA primary care dentist to coordinate your referral.[6]
What is my out-of-area coverage?	You can visit any licensed dentist.	You have a limited benefit to go out of network for emergency care.
How do I change my dentist?	You can change your dentist at any time without contacting us.	You can change your selected or assigned primary care dentist online or by telephone.[7]
Do I need to fill out claims?	If you visit a Delta Dental dentist, the dental office will file the claim for you. If you go to a non–Delta Dental dentist, you may have to submit the claim yourself.	There are generally no claim forms under your plan.[8]

[4] In AK, CT, ND and SD, you have an out-of-network calendar year maximum of $500 when you visit an out-of-network dentist.

[5] Except in Texas; please refer to your plan booklet for details.

[6] Most services not performed by your primary care dentist must be authorized by Delta Dental. In some states, specialty care benefits are only available for services performed by an in-network specialist. Refer to your plan booklet for details.

[7] In the following states, you can change your dentist any time without contacting Delta Dental: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT, WY.

[8] You may have to complete a claim form if you visit an out-of-network dentist, such as for limited emergency treatment or in the following states: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Delta Dental PPO is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA – Delta Dental of California; PA, MD – Delta Dental of Pennsylvania; NY – Delta Dental of New York, Inc.; DE – Delta Dental of Delaware, Inc.; WV – Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

EF3_PPO_DCU #133202B (rev. 08/21)

Understand your plan

What you can do:

- Browse answers to frequently asked questions.
- Get tips on planning for a dental visit.
- Find claim forms.
- Learn how to go paperless, sign up for a virtual dental visit and coordinate coverage with two or more plans.

Try it out: Visit **deltadentalins.com/enrollees** for useful resources and tips.

Explore dental wellness

What you can do:

- Browse articles on everything from acid reflux to xylitol.
- Find delicious recipes for healthy meals.
- Check out videos on preventive care and common procedures.

Try it out: Visit **deltadentalins.com/wellness** to start learning.

Download the app

What you can do:

- Check your plan details and eligibility.
- Browse claim history.
- View your member ID card.
- Get a cost estimate.
- Find an in-network dentist.

Try it out: Search for Delta Dental in the App Store or Google Play.

Tip: Don't need another app? Just visit **deltadentalins.com** on your smartphone or tablet and log in to your account.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

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Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: 11B – BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 3 **Name of Product:** DeltaCare® USA
Type of Product Line: DHMO **Plan Phone #:** 800-422-4234
Plan Name: Beginning on or after – 07/01/2024 **Plan Website:** deltadentalins.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE deltadentalins.com OR CALL 800-422-4234.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	Not Applicable

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	None	Not applicable
Lifetime Maximum for Orthodontia	None	Not applicable

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. **Not all services accrue to the annual maximum**.
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package has no waiting period.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventative & Diagnostic	$0	Not covered	- No limitations or exclusions.
Bitewing X-ray	Preventative & Diagnostic	$0	Not covered	- No limitations or exclusions.

Cleaning	Preventative & Diagnostic	$0	Not covered	- 1 per 6 month period.
Filling	Basic	$0	Not covered	- No limitations or exclusions.
Extraction, Erupted Tooth or Exposed Root	Basic	$5	Not covered	- No limitations or exclusions.
Root Canal	Basic	$250	Not covered	- No limitations or exclusions.
Scaling and Root Planing	Basic	$25	Not covered	- Limited to 4 quadrants during any 12 consecutive months.
Ceramic Crown	Major	$240	Not covered	- Replacement of crowns, inlays and on lays requires the existing restoration to be 5+ years old.
Removable Partial Denture	Major	$160	Not covered	- Replacement of a partial denture requires the existing denture to be 5+ years old.
Extraction,Erupted Tooth with Bone Removal	Basic	$25	Not covered	- No limitations or exclusions.
Orthodontia	Orthodontia	$1,700	Not covered	- The listed copayment for each phase of orthodontic treatment covers up to 24 months of active treatment. - Beyond 24 months, an additional monthly fee not to exceed $125, may apply.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below 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 the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (Full-mouth x-ray) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $**400** Out-of-network: $**550**	Total Cost of Care	In-network: $**150** Out-of-network: **$200**	Total Cost of Care	In-network: $**1,300** Out-of-network: $**1,750**
Deductible	In-network: None Out-of-network: Not covered	Deductible	In-network: None Out-of-network: Not covered	Deductible	In-network: None Out-of-network: Not covered
Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not covered	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not covered	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not covered

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: Not covered	Patient Cost (copayment or coinsurance)	In-network: $55 Out-of-network: Not covered	Patient Cost (copayment or coinsurance)	In-network: $240 Out-of-network: Not covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $55 **Out-of-network:** $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $240 **Out-of-network:** $1,750
Summary of what is not covered or subject to a limitation:	**Exam:** - No limitations or exclusions. **X-rays (FMX):** Full mouth x-ray is limited to 1 series every 24 months. **Cleaning:** Cleaning is limited to 1 per 6 month period.	Summary of what is not covered or subject to a limitation:	- No limitations or exclusions.	Summary of what is not covered or subject to a limitation:	- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

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GRANDFATHERED HEALTH PLAN NOTICE

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits, effective for this plan on July 1, 2011.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

BeneSys Administrators
P.O. Box 1607, San Ramon, CA, 94583
Tel: (888) 208-0250

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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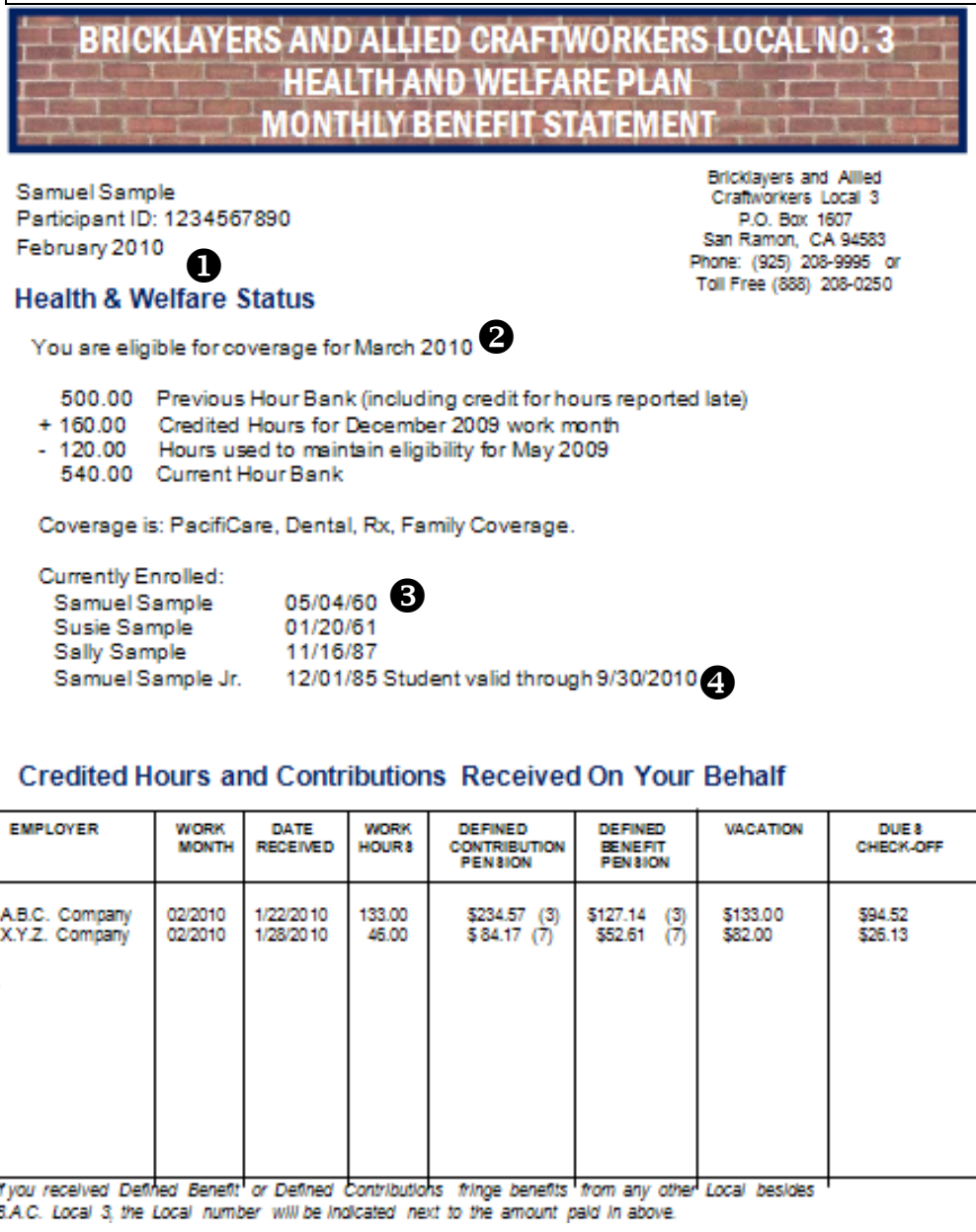
How to Read Your Monthly Benefit Statement



BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 3
HEALTH AND WELFARE PLAN
MONTHLY BENEFIT STATEMENT

Samuel Sample
Participant ID: 1234567890
February 2010 ❶

Bricklayers and Allied
Craftworkers Local 3
P.O. Box 1607
San Ramon, CA 94583
Phone: (925) 208-9995 or
Toll Free (888) 208-0250

Health & Welfare Status

You are eligible for coverage for March 2010 ❷

500.00	Previous Hour Bank (including credit for hours reported late)
+ 160.00	Credited Hours for December 2009 work month
- 120.00	Hours used to maintain eligibility for May 2009
540.00	Current Hour Bank

Coverage is: PacifiCare, Dental, Rx, Family Coverage.

Currently Enrolled: ❸

Samuel Sample	05/04/60
Susie Sample	01/20/61
Sally Sample	11/16/87
Samuel Sample Jr.	12/01/85 Student valid through 9/30/2010 ❹

Credited Hours and Contributions Received On Your Behalf

EMPLOYER	WORK MONTH	DATE RECEIVED	WORK HOURS	DEFINED CONTRIBUTION PENSION	DEFINED BENEFIT PENSION	VACATION	DUES CHECK-OFF
A.B.C. Company	02/2010	1/22/2010	133.00	$234.57 (3)	$127.14 (3)	$133.00	$94.52
X.Y.Z. Company	02/2010	1/28/2010	46.00	$84.17 (7)	$52.61 (7)	$82.00	$26.13

❺

If you received Defined Benefit or Defined Contributions fringe benefits from any other Local besides B.A.C. Local 3, the Local number will be indicated next to the amount paid in above.

❶ Date of the Monthly Benefit Statement.

❷ This area indicates if you are eligible for Health Care and under what plan. Other messages may also appear here, depending on your eligibility status.

❸ This area lists those enrolled under your coverage and their birth dates. Contact the Fund Office if any information is incorrect or missing. It is important to keep this information accurate to avoid breaks in coverage.

❹ Dependents over age 18 must be full-time students to be covered. You are required to submit full-time student certification each semester. This area will show the date your student certification is valid through.

❺ The hours/contributions reported by your employer are listed here. Expect a **one month delay** between when you work and when the hours appear on this Benefit Statement. For example, work you perform in January should be on your March Status Report. Contact the Fund Office if you worked for an employer that is not listed or the information is incorrect

If you have any questions on how to read your monthly benefit statement or the information reported on your statement, please contact the Benefit Office at:

B.A.C. Local 3 Trust Funds
7180 Koll Center Parkway, Suite 200,
Pleasanton, CA 94566
P.O. Box 1607 · San Ramon, CA 94583
(925) 208-9995 or (888) 208-0250
www.bac3-brickbenefits.org · staff@bac3-brickbenefits.org

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

PRIVACY PRACTICES NOTICE

October 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 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. 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:

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 SEPTEMBER 23, 2013.

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

Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you have recently become covered under the Bricklayers and Allied Craftworkers Local No. 3 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: Bricklayers and Allied Craftworkers Local No. 3 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 last 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 Bricklayers and Allied Craftworkers Local No. 3 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: Bricklayers and Allied Craftworkers Local No. 3 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.

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: Bricklayers and Allied Craftworkers Local No. 3 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.

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

BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 3
HEALTH AND WELFARE TRUST FUND
October 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	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants	Website: https://www.flmedicaidtplrecovery.com/

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 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	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

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

October 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 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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Employee Benefits

Portability vs. Conversion

If your group coverage ends or reduces, you may be eligible to continue ("port") your employer sponsored life/accidental death & dismemberment insurance to a group term life insurance policy or convert your life insurance policy to an individual whole life insurance policy in order to maintain coverage.

The grid below outlines the differences between Portability and Conversion to help you determine the best option for you. If you have any questions regarding the Portability or Conversion process, please contact your Benefits Administrator or take advantage of the toll-free number provided by Mutual of Omaha Insurance Company. You can reach a service representative by calling (877) 466-8367, Monday through Friday 9:00 a.m. to 5:00 p.m. (Eastern Standard Time).

	Portability	Conversion
Availability	Standard with voluntary life plans Optional with basic life	Standard with all plans
Coverage Continues as	Group Term Life Insurance	Individual Whole Life Insurance
Eligibility	Employee and/or spouse are under age 70 when group coverage ends	Group life coverage terminates or is reduced for any reason
Children	Eligible as long as employee and/or spouse has ported coverage	Eligible if group life coverage terminates or is reduced for any reason
Election Period	Request form must be received within 31 days of employer sponsored insurance ending	Application must be received within 31 days of employer sponsored insurance ending/ reducing
Medical Information	None required	None required
Rates	Based on amount of insurance and age	Based on amount of insurance, gender and age
Billing Options	Quarterly, semiannually, annually	Quarterly, semiannually, annually
Cash Value	No (Term Insurance)	Yes (Permanent Insurance)
Termination	Age 70 for Employee and/or Spouse Limiting age for children 26	Death
Living Benefit	Included	Not included
Minimum	Employee: $10,000 Spouse: $5,000 Dependents: $2,000	$1,000 increments
Maximum	Lesser of prior coverage under group plan or $500,000 for Employee or $250,000 for Spouse	Amount of prior coverage under group plan

Underwritten by
United of Omaha Life Insurance Company
Companion Life Insurance Company
Mutual of Omaha Affiliates

CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GLUG-9H86 (the Policy) has been issued to B.A.C. Local #3 Health and Welfare Trust Fund (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You and Your Dependent(s), if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Jay C. Vanbeat
Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLASS(ES)

All eligible employees - 1

LIFE INSURANCE FOR YOU (THE EMPLOYEE)

Your amount of life insurance is $10,000.

Your amount of life insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule. If You have questions regarding the amount of Your life insurance, You may contact the Policyholder.

LIFE INSURANCE FOR YOUR DEPENDENT(S)

Your Spouse's amount of life insurance is $2,500.

The amount of life insurance for Your eligible Dependent child(ren) is based on the age of the Dependent, as follows:

Age of Dependent Child	Amount of Life Insurance
Six months and older	$1,000
14 days to less than six months	$1,000
Less than 14 days	$1,000

If You have questions regarding the amount of life insurance for Your Dependent(s), You may contact the Policyholder.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU

Your amount of accidental death and dismemberment (AD&D) insurance is equal to Your amount of life insurance.

Your amount of AD&D insurance is also referred to as the Principal Sum. Your amount of AD&D insurance is subject to any reductions indicated in the Benefit Reductions provision of this Schedule. If You have questions regarding the amount of Your AD&D insurance, You may contact the Policyholder.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

Guarantee Issue Amount(s) is/are subject to any reductions indicated in the Benefit Reductions provision of this Schedule.

Guarantee Issue Amount For You (The Employee)

Your Guarantee Issue Amount is $10,000, unless You were insured under a Prior Plan. If You were insured under a Prior Plan, Your Guarantee Issue Amount is equal to the amount of insurance that was in-force for You under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance stated in the Life Insurance for You (the Employee) section of this Schedule.

Guarantee Issue Amount For Your Spouse

The Guarantee Issue Amount for Your Spouse is 100% of Your elected amount of life insurance or $0, whichever is less, unless Your Spouse was insured under a Prior Plan. If Your Spouse was insured under a Prior Plan, the Guarantee Issue Amount for Your Spouse is equal to the amount of insurance that was in-force for Your Spouse under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance for Your Spouse stated in the Life Insurance for Your Dependent(s) section of this Schedule.