

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

May 2025

TO: ACTIVE PARTICIPANTS IN CALIFORNIA

RE: JULY 1, 2025 OPEN ENROLLMENT – MEDICAL AND DENTAL COVERAGE

The Board of Trustees has completed negotiations with the HMO and dental carrier for rates effective July 1, 2025, through June 30, 2026. The enclosed page shows the charge-off rates effective July 1, 2025, for each combination of medical and dental options.

The Board had difficult negotiations with Kaiser resulting in higher annual medical costs. Due to the result of these negotiations, the Trustees have elected to increase the annual subsidy in California to help with the increased costs of medical care. Please reference the Charge-Off sheet for the two Options and their respective subsidies.

OPEN ENROLLMENT

If you would like to change your coverage effective July 1, 2025, please complete the enclosed Change of Coverage Request form ***as well as the necessary enrollment forms. You will not be allowed to change your coverage unless you return the completed HMO or dental plan enrollment application to the Fund Office by Friday, June 20, 2025.*** Completed forms may be faxed to 925-462-0108.

MEDICAL

With the exception of emergency treatment, no benefits are available for services and supplies provided by doctors and hospitals not contracted with Kaiser. Attached is a brief summary of benefits for your reference. However, you should consult the ***Evidence of Coverage*** from Kaiser for complete information about benefits and limitations.

DENTAL

The Standard Dental Plan is an indemnity plan, which allows you to use the services of any dentist of your choice. The plan covers a portion of the allowable dental expenses according to its schedule of usual and customary charges. You must file a claim form to receive benefits.

VISION

There are no changes to the vision plan effective July 1, 2025.

We remind you that dependent changes, i.e., marriage, divorce, birth of a child, or a child reaching the age of 26, must be reported to the Trust Fund office ***within 30 days of occurrence*** to ensure a proper eligibility effective date. Please note that proper proof of dependent status must be provided to the Trust Fund office.

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, please contact the Fund Office.

In accordance with the reporting requirements of the Employee Retirement Income Security Act of 1974, as amended, this document serves as your Summary of Material Modifications to the Plan.

Pacific Coast Shipyards Metal Trades Trust Fund
Final Cost of Coverage / Dollar Bank Charge-off
July 2025 California

OPTION 1	OPTION 2
Kaiser Medical	\$2,299.26
Standard Dental	105.92
Vision	5.15
Life insurance	<u>4.50</u>
Actual Cost of Benefits	\$2,414.83
Trust Fund Subsidy *	\$881
Your Charge-off	\$1,534
Kaiser Medical	\$2,299.26
Life insurance	<u>4.50</u>
Actual Cost of Benefits	\$2,303.76
Trust Fund Subsidy *	\$877
Your Charge-off	\$1,427

* Effective July 1, 2025, the Board approved changing the subsidy from \$559 to \$881 (Option 1) and \$877 (Option 2) in California. Please note that the Trustees may reduce or eliminate the subsidy at any time for any reason.

**Pacific Coast Shipyards Metal Trades Trust Fund
Change of Coverage Request – CALIFORNIA
Effective July 1, 2025**

MEDICAL

- Check this box only if you are not already enrolled in medical coverage.
 - I would like to enroll in **Kaiser**. (Fax this form as well as the enclosed Pacific Coast Shipyards Metal Trades Trust Fund enrollment form to **925-462-0108**).
- Check this box only if you are not already enrolled in dental plan.
 - I would like to enroll in **Standard Dental**. (Fax this form as well as the enclosed Standard Dental enrollment form to **925-462-0108**)
- Check this box only if you wish to *DROP* your dental and vision benefits.
- Check this box if you need to update the Fund Office information about your address or dependents. You may use the enclosed Pacific Coast Shipyards Metal Trades Trust Fund enrollment form to do so. Please note that proper proof of dependent status must be provided to the Trust Fund office.

YOU AND YOUR DEPENDENTS DO NOT HAVE ANY MEDICAL INSURANCE, EVEN IF YOU MEET THE ELIGIBILITY REQUIREMENTS, UNLESS YOU COMPLETE AN ACTUAL ENROLLMENT FORM.

I understand that this Change of Coverage Request form is not an HMO or dental plan application and that any change in my benefits will become effective July 1, 2025 only if I complete the actual application for the HMO or dental plan and return it to the Trust Fund office by **June 20, 2025**.

Signed: _____

Print Name: _____

Address: _____

Dated: _____

Home Phone: _____

Social Security #: _____

Work Phone: _____

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

ENROLLMENT FORM

Date of Hire: _____

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

EMPLOYEE'S FULL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____ EMAIL: _____

<u>MEDICAL PLAN: CALIFORNIA (CHOOSE ONE):</u>	<u>DENTAL (Provided By):</u>	<u>VISION (Provided By):</u>
<input type="checkbox"/> KAISER PERMANENTE HMO PLAN (Active Grp# 8012-0) <input type="checkbox"/> KAISER PERMANENTE HMO PLAN (Retiree Grp# 8012-1) **If enrolling in Kaiser you must also sign the Kaiser Arbitration Agreement below**	<input type="checkbox"/> STANDARD DENTAL(PPO) **Complete enclosed Dental Plan Enrollment Form or Declination of Coverage Form. **	VISION SERVICE PLAN (VSP)

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

DEPENDENTS - (Including Spouse)

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

FULL 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 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 of benefits.

MEMBER SIGNATURE _____

DATE: _____

enrollment/change/waiver Group Insurance Form

Standard Insurance Company P.O. Box 82622, Lincoln, NE 68501-2622 / 877-490-9991 / Fax: 402-467-7338



Policy and Div. # 160- _____

Cert. # _____

COBRA: If individual
is a continuee:

Qualifying Event

Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll Dental To terminate all coverages

Employee Information

Marital Status Single Married Civil Union* Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth _____ Male Female Full time date of hire _____ Rehire: Rehire date _____

Occupation _____ Hours worked each week _____ Are your earnings paid: Hourly or Salaried

Street address _____ City _____ State _____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? **Employee:** Yes No **Dependents:** Yes No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first, MI)	Dental		Relationship	Sex	Date of birth	Social Security no.	College student?
	add	drop					
1	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>

Please Sign (employee/policyholder) The certificate provides dental benefits only. Review your certificate carefully.

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. **THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:** I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X

Employee Signature (do not print)

Date

X

Policyholder Signature (do not print)

Date

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date _____

Effective Date

Class

Dep. Code

Dependent late entrant date _____

2 to change

Name Change New Name _____ Old Name _____

Add Dependent Coverage

If due to marriage, what is the date of marriage? _____ If due to birth/adoption, what is the date of event? _____

If due to loss of coverage, date and reason: _____

If other, the date of event and please explain: _____

Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop: _____

Due to divorce Due to death Due to annual election period Exceeds maximum age to qualify as dependent

Other (please explain) _____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

myself (does not apply to TRUST policies) spouse/domestic partner child(ren) only spouse/domestic partner and child(ren)

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For group policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-3797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Note for Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Note for Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Maryland Insureds: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico and Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

Note for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note for Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Note for Texas Residents: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Note for Washington, D.C. Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number** – to make sure plan members are added to the correct group.
- **Department/Division Numbers** – so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers** – the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date** – needed so the correct effective date is calculated for new members.
- **Class Number** – needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

- 1) submit clear, legible enrollment forms.
- 2) underline or circle important information.
- 3) use blue or black ink.

Don't:

- 1) submit dark copies as they appear black on imaging.
- 2) highlight, which blackens the area so it cannot be read.
- 3) write on the top or bottom margins. This information is not always captured on the image system.

**PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND
(FOR CALIFORNIA ACTIVES)**

HMO BENEFITS - JULY 1, 2025 THROUGH JUNE 30, 2026

KAIser (NORTHERN CALIFORNIA)	
HOSPITALIZATIONS AND RELATED MEDICALLY NECESSARY SERVICES	\$500 copayment per day
PHYSICIAN OFFICE VISITS	Primary Care: \$40 copayment per visit. Specialist: \$50 copayment per visit.
X-RAY AND LABORATORY SERVICES	\$10 copayment per encounter
PREVENTIVE AND WELLNESS CARE	\$0 member copayment for pre-natal and well-baby exams (through age 23 months). \$0 member copayment for adult exams and all hearing and eye exams. Immunizations are provided at no charge. \$5 per visit for allergy injections.
MENTAL HEALTH CARE INPATIENT	\$500 copayment per day
OUTPATIENT	\$40 member copayment (\$20 for group therapy) Certain serious mental disorders are covered the same as other medical conditions as specified by California law AB 88.
OUTPATIENT SURGERY	\$250 per procedure
SUBSTANCE ABUSE INPATIENT	Detoxification: \$500 copayment per day
OUTPATIENT	\$40 member copayment (\$5 for group therapy) per visit. (No limit on number of visits).
AMBULANCE	Covered with \$150 copayment when medically necessary and authorized by a Plan physician.
SKILLED NURSING FACILITY	No charge, up to 100 days per benefit period.
PRESCRIPTION DRUGS	Retail up to a 30-day supply: \$15 member copayment per generic prescription \$35 member copayment per brand name prescription Mail Order up to a 100-day supply: \$30 member copayment per generic refill \$70 member copayment per brand refill Specialty: 30% coinsurance (not to exceed \$250), up to a 30-day supply In accordance with Health Plan formulary.
PHYSICAL AND OTHER THERAPIES	\$40 member copayment per visit
EMERGENCY CARE	\$150 member copayment per visit; waived if admitted.
This is only a summary of the coverages actually provided by the above specified benefit program. All exclusions and limitations have not been included and may vary. This summary is not to be construed or accepted as a substitute for the provisions of each master policy or contract which will be controlling in case of a conflict. Retiree benefits are not guaranteed. The Board of Trustees reserves the right to modify the benefits, change HMOs, or terminate the Plan entirely at any time.	

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

Date: **May 2025**
To: **Kaiser of California Active and Non-Medicare Retiree Participants and Dependents (including COBRA beneficiaries)**
From: **Board of Trustees**
Subject: **Summary of Benefits and Coverage (SBC)**

**This information is VERY IMPORTANT to you and your dependents.
Please take the time to read it carefully**

Attached you will find a document called a **Summary of Benefits and Coverage**, commonly referred to as a “**SBC**”. This SBC provides a brief overview of the medical plan benefits by **Kaiser of California**. You will want to review this and share it with your other family members who enroll for coverage.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical benefits.

What the SBC Contains

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. Government regulations are very specific about the information that can and cannot be included in each SBC. Plan sponsors are not allowed to customize very much of the SBC. An SBC includes: a health plan comparison tool called “**Coverage Examples**”, a link to a “**Glossary**” of common terms used in describing health benefits, and **Website and toll-free phone numbers** you can contact if you have questions or need assistance with benefits.

When You Will Receive an SBC

The SBC will be provided to you at important points in the enrollment process, such as when you apply for coverage, with each annual open enrollment, and at any time you want, upon request. Distribution of the SBC is required by law in accordance with Affordable Care Act (ACA).

60-Day Notice for Material Modification of Plan Benefits

If material change is made to a medical plan during the plan year that is not reflected in the most recent Summary of Benefits and Coverage (SBC), a notice will be provided to you at least 60 days before the effective date of the change. A material change is any change that would be considered by an average participant to be an important enhancement or reduction in benefits. This 60-day notice applies to changes that become effective during the plan year. Changes made at the beginning of a new plan year do not require 60-day advance notice.

* * * * *

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. Should you have any questions, please contact Kaiser 800-278-3296.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see

<https://kp.org/plandocuments> or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$3,000 Individual / \$6,000 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	\$40 / visit	Not Covered	None
	Specialist visit	\$50 / visit	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	\$100 / procedure	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	Retail: \$15 / prescription ; Mail order: \$30 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs (Tier 2)	Retail: \$35 / prescription ; Mail order: \$70 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines.
	Non-preferred brand drugs (Tier 2)	Retail: \$35 / prescription ; Mail order: \$70 / 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)	30% coinsurance up to \$250 / 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)	\$250 / 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	\$150 / visit	\$150 / visit	None
	Emergency medical transportation	\$150 / trip	\$150 / trip	None
	Urgent care	\$40 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: \$40 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 / day	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	\$40 / individual visit. No Charge for other outpatient services	Not Covered	Mental / Behavioral Health: \$20 / group visit; Substance Abuse: \$5 / group visit.
	Inpatient services	\$500 / day	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	\$500 / day	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient: \$500 / day; Outpatient: \$40 / visit	Not Covered	None
	Habilitation services	\$40 / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	100 day limit / benefit period.
	Durable medical equipment	50% coinsurance	Not Covered	Requires prior authorization.
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

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

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

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

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

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.ccio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.dmhc.ca.gov

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

Language Access Services:

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

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

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

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

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

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

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	\$0
Specialist copayment	\$50
Hospital (facility) copayment	\$500
Other (blood work) copayment	\$10

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$50
The total Peg would pay is	\$650

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	\$50
Hospital (facility) copayment	\$500
Other (blood work) copayment	\$10

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$300

What isn't covered

Limits or exclusions	\$0
The total Joe would pay is	\$1,400

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	\$0
Specialist copayment	\$50
Hospital (facility) copayment	\$500
Other (x-ray) copayment	\$10

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$500

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente¹ 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.

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 مجاناً على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق لغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مراقبنا. اتصل مع مركز اتصال خدمة الأعضاء لدينا، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع (العطلات مغلقة).

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

Armenian: Ձեզ կարող եք 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 եք):

- 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 به صورت 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 تطبيقات) با مرکز خدمات اعضای ما تماس بگیرید.

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

Hindi: बिना किसी लागत के भाषा सहायता, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप दुर्भाषिये 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 घण्टे, सप्ताह के सातों दिन (छह दिन बाले 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): ជំនួយភាសាអីស្សាគិកតិកបែងប្រើប្រាស់ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ម៉ោងក្នុងមួយសប្តាហ៍ អកអាប់សីសំស្របអកប្រក្រុប បង្កិតសារ ដែលបានក្រុមប្រើប្រាស់បន្ថែមដើរក្នុងសម្រាប់ក្រុមប្រើប្រាស់ អកអាប់សីសំស្របអកប្រក្រុប ទៅការទឹន្នន័យ ដែលបានក្រុមប្រើប្រាស់បន្ថែមដើរក្នុងសម្រាប់ក្រុមប្រក្រុប 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ម៉ោងក្នុងមួយសប្តាហ៍ (ម៉ោងយប់សម្រាប់បន្ថែមទីផ្សារ)។

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

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스 또는 귀하의 언어로 번역 된 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: ມີການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ແສຍຄູ່ໃຫ້ແກ່ທ່ານ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ, ທ່ານຍັງສາມາດຂໍບໍລິການຜູ້ແປພາສາ ຫຼື ເອກະສານທີ່, ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໄດ້. ທ່ານຍັງສາມາດຂໍອປະກອນຊ່ວຍເສີມ ແລະ ເຄືອງມືຢູ່ສະຖານບໍລິການຂອງພວກເຮົາໄດ້. ໂທ່າສູນຕິດຕໍ່ບໍລິການສະມາຊີກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ (ປິດໃນວັນພຶກ).

- Medi-Cal: **1-855-839-7613 (TTY 711)**
- ອື່ນ່າງໜີ້ດ: **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 horng jaa-sic zoux benx meih nyei waac. Meih corc haih tov tengx nyungc horng jaa-dorngx aengx caux jaa-sic

nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Beiv hnangv qiempx 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 nádáhágíí yádi nihookaa. Shí éí bee háidíniibibee' haz'áanii dóó bee t'ah kodí bízíkinii wo'da'gi doolyé. Ahéhee' bik'ehgo nohólqon'ííí, 24 t'áadawołíí, 7 t'áadawołíígo (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, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਲਈ, ਜਾਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋਏ ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸੱਧਾਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਮਦਦ ਲਈ ਸਾਡੀ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਕਾਲ 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 คุณสามารถรู้ขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการของเราระยะห่างที่ศูนย์ติดต่อฝ่ายบริการสมาชิกของเราระบุความช่วยเหลือตลอด 24 ชั่วโมงทุกวัน (ปิดทำการในช่วงวันหยุด)

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

Ukrainian: 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 пристройів у закладах нашої мережі компаній. Телефонуйте в наш контактний центр для обслуговування клієнтів цілодобово, 7 днів на тиждень (крім свяtkових 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 phuơng tiện trợ giúp và thiết bị hỗ 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)**

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

Important Employee Benefit Program Notices

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Medical Plan options available to you are creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan options offered by the Fund are creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage available from the Trust Fund Office at (925) 398-7056.

IMPORTANT: After the open enrollment period is completed, (or, if you are a new hire, after your initial enrollment election period is over), generally you **will not** be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment Event as outlined below:

- **Special Enrollment Event:**

Loss of Other Coverage Event: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must **request enrollment within 31-days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

Marriage, Birth, Adoption Event: In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must **request enrollment within 31-days** after the marriage, birth, adoption, or placement for adoption.

Medicaid/CHIP Event: You and your eligible dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact Trust Fund Office at (925) 398-7056.

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: <http://www.socialsecurity.gov/online/ss-5.pdf>. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact Trust Fund Office at (925) 398-7056.

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. You can get another copy of this Notice from your HMO or the Trust Fund Office at (925) 398-7056.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by the Fund. For more information on WHCRA benefits, contact the Trust Fund Office at (925) 398-7056.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

The Kaiser HMO and the UnitedHealthcare (UHC) HMO generally require the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the HMO designates one for you. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the HMO.

Direct Access to OB/GYN Providers:

You do not need prior authorization (pre-approval) from the Trust Fund, Kaiser, UHC or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the HMO.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohiba.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</p> <p>Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahpp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US</p> <p>Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: massprem assistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p>Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/</p>
VERMONT – Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>	<p>Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924</p>
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
<p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>	<p>Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
<p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>	<p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

Life Insurance Beneficiary Designation

I, _____, Social Security Number _____
(Print Name)

Do hereby designate the following named persons as my beneficiary or beneficiaries to receive any monies that may be payable by reason of my death, under the Pacific Coast Shipyards Metal Trades Trust Fund. (If additional space is needed, please use second sheet)

Beneficiary Name:	Date of Birth:
SSN:	Relationship:
Address:	Phone:
Percentage of Benefit to be Received: (see examples below*) %	
Beneficiary Name:	Date of Birth:
SSN:	Relationship:
Address:	Phone:
Percentage of Benefit to be Received: %	
Beneficiary Name:	Date of Birth:
SSN:	Relationship:
Address:	Phone:
Percentage of Benefit to be Received: %	
Beneficiary Name:	Date of Birth:
SSN:	Relationship:
Address:	Phone:
Percentage of Benefit to be Received: %	
Secondary Beneficiary Name: (see explanation below*)	
Date of Birth:	
SSN:	Relationship:
Address:	Phone:

(Over)

Custodial Designation:

If my above named beneficiary is a minor, I hereby designate (print full name) _____ to act as Custodian to receive such benefits on behalf of such child (or children). I understand that I may change this Custodial Designation at any time. I also understand that if I fail to name a Custodian, then the natural parent(s) of the minor will automatically be designated as Custodian. I also understand that if the amount of the benefit is more than \$10,000, and I fail to name a Custodian, the benefit cannot be paid until a Custodian is appointed by the Superior Court.

Custodian Name: _____ **Date of Birth:** _____

Date of Birth: _____

SSN: _____ Relationship: _____

Relationship: _____

Address: _____ **Phone:** _____

Phone: _____

*If you designate more than one 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 beneficiaries you may state that one will receive 75% and the other 25%. Benefits will be paid to the person you list as a Secondary Beneficiary only in the event your designated Beneficiaries 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 Trust rules.

Check one:

Single Divorced Separated
 Widowed Married *(if checked, fill in date)* _____

Member's Signature: _____ **Date:** _____

Spouse's Signature:** _____ **Date:** _____

**If you are currently married and are naming someone other than your spouse as your beneficiary your spouse must also sign this Beneficiary Designation Form. Your beneficiary designation will be automatically deemed revoked upon certain changes in marital status. If you are currently married and later divorce, your beneficiary designation of your spouse will be deemed revoked unless a Court order requires you to maintain the beneficiary designation you are making at this time. If you are currently single and later marry, the beneficiary designation you are making at this time will be automatically revoked unless the person you are naming as your beneficiary at this time is the person who becomes your spouse. Should your beneficiary be automatically revoked due to either of the foregoing events benefits will be paid to your estate.