PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

May 2023

TO: ACTIVE PARTICIPANTS IN **WASHINGTON**

RE: JULY 1, 2023 OPEN ENROLLMENT – MEDICAL AND DENTAL COVERAGE

The Board of Trustees have completed negotiations with all HMO and dental carriers for rates effective July 1, 2023 through June 30, 2024. The enclosed page shows the charge-off effective July 1, 2023 for each combination of medical and dental options.

OPEN ENROLLMENT

If you would like to change your coverage effective July 1, 2023, 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 16, 2023.** 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

A brief comparison of benefits under Standard Dental and Dental Health Services (DHS) is enclosed. Under DHS you pay set copayments for services and you must select a DHS dentist to receive care. A directory is available from the Trust Fund office. 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, 2023.

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.

7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566 • P O Box 2510 • San Ramon, CA 94583
Phone 925-398-7056 • Toll Free 844-403-0032 • Fax 925-462-0108

Pacific Coast Shipyards Metal Trades Trust Fund
Cost of Coverage / Dollar Bank Charge-off
July 2023 Washington

OPTION 1	
Kaiser Medical	$1,397.47
Standard Dental	101.87
Vision	5.45
Life insurance	3.80
Actual Cost of Benefits	**$1,508.59**
Trust Fund Subsidy *	-$300.00
Your Charge-off	**$1,209**

OPTION 2	
Kaiser Medical	$1,397.47
Dental Health Services	47.56
Vision	5.45
Life insurance	3.80
Actual Cost of Benefits	**$1,454.28**
Trust Fund Subsidy *	-$300.00
Your Charge-off	**$1,154**

OPTION 3	
Kaiser Medical	$1,397.47
Life insurance	3.80
Actual Cost of Benefits	**$1,401.27**
Trust Fund Subsidy *	-$300.00
Your Charge-off	**$1,101**

Note on Option 3:
If you drop your dental and vision coverage and later wish to re-enroll for those benefits, you will need to enroll in the Dental HMO plan for the first 24 months.

*** At the May 1, 2023 meeting, the Board voted to increase the Trust Fund Subsidy from $200 to $300 effective July 1, 2023. 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 – WASHINGTON
Effective July 1, 2023

MEDICAL

- ❑ Check this box only if you are not already enrolled in medical coverage.
  - ❑ I would like to enroll in **Kaiser of Washington**. (Fax this form as well as the enclosed Kaiser of Washington enrollment form to **925-462-0108**)

DENTAL

- ❑ Check this box only if you wish to *change* your 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**)
  - ❑ I would like to enroll in **Dental Health Services**. (Fax this form as well as the enclosed Dental Health Services (DHS) enrollment form to **925-462-0108**)

- ❑ Check this box only if you wish to *DROP* your dental and vision benefits. (Please note that if you drop your dental and vision benefits, you will be required to enroll in the Dental HMO option for the first 2 years after you re-enroll for these benefits.)

- ❑ Check this box if you need a new enrollment form to update the Fund Office information about your address or dependents. 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 FOR KAISER OF WASHINGTON.

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, 2023 only if I complete the actual application for the HMO or dental plan and return it to the Trust Fund office by ***June 16, 2023.***

Signed: _____ Print Name: _____

Address: _____

Dated: _____ Home Phone: _____

Social Security #: _____ Work Phone: _____

KAISER PERMANENTE®

Return completed form to
P.O. Box 23219, San Diego, CA 92193-9921

2023 Employee enrollment and change form

EMPLOYER: PLEASE COMPLETE THIS SECTION.

Effective date_____
Termination date _____
Group name_____
Group number_____
Selected health plan _____
Pay location (if applicable)_____

Original date of hire ____/____/____
Date of rehire ____/____/____
Date transferred from part time (p/t) to full time (f/t) ____/____/____
Hours worked per week _____
If retired, date of retirement ____/____/____

Choose one:

☐ Open enrollment
☐ New employee
☐ Address/name change
☐ Add dependent(s)
☐ Remove coverage
  ☐ Employee
  ☐ Dependent(s)
☐ Qualifying event _____

Date processed ____/____/____ by _____

☐ **Transfer to COBRA**
Start date ____/____/____
☐ 18 months
☐ 36 months

Reminder to employers: For groups already enrolled in direct policies, enrollment and changes can be made online via our Business Portal.

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____ Mobile phone* (_____)_____
(Last name) (First name) (M.I.)

Resident address _____ Home phone* (_____)_____
(Street) (City) (State) (ZIP)

Mailing address (if different) _____ Email address* _____

Former name of applicant or spouse/domestic partner (if applicable) _____

* I understand that Kaiser Permanente may contact me via email or text messaging.

For health plan internal use only	Check one		Please print Last name First name M.I.	Social Security number	Male/ Female	Birthdate (MM/DD/YY)	Relationship to employee
	Add	Remove					
			Self				
			Spouse/domestic partner/dependent (circle one)				
			Dependent				
			Dependent				
			Dependent				

_____
(Signature of employee) (Date signed)

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. Dependent children are eligible for coverage through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan. Dependents are not required to reside with the subscriber. Dependents are not required to be dependent upon the subscriber for support. Eligibility for medical assistance is not considered when determining eligibility for coverage or making payments. In Washington state, a registered domestic partner is treated the same as a spouse. If children of the primary insured are covered, children of a domestic partner are eligible for coverage on the same basis. All plans offered and underwritten by Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 1300 SW 27th St., Renton, WA 98057.

CLEAR FORM

enrollment / change / waiver Group Insurance Form

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

TheStandard®

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 add	Dental drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐					☐
2	☐	☐					☐
3	☐	☐					☐
4	☐	☐					☐
5	☐	☐					☐

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 _____ X _____

Employee Signature (do not print) **Date** **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_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

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.

Dental Health Services Inc.

Enroll today!

You are now eligible for membership in a Dental Health Services, Inc (Dental Health Services) dental Plan. You and your family now have an affordable, quality alternative to high dental costs and traditional dental insurance. We look forward to the opportunity to serve you!

How does my plan work?

Your dental Plan allows you and your family to receive service from a network of local, independently owned, quality assured dental offices. Using the plan is easy. Simply select a conveniently located Quality Assured Participating Dentist, who will then assess your oral health and outline an appropriate treatment plan. Your care then proceeds according to this treatment plan. Most procedures require you to pay a Copayment, as listed in the enclosed Schedule of Covered Services and Copayments.

What is a Copayment?

A Copayment is the amount that you owe at the time covered Benefits under this Plan are received. The Copayment amounts for covered Benefits are listed on the Schedule of Covered Services and Copayments document. Copayments are paid directly to the provider at the time services are rendered.

How do I receive dental care?

As soon as you are enrolled and your Plan has become effective, simply telephone your selected dental office and ask for an appointment time that works best for you. Your Selected Participating Dentist receives an updated membership list every month, so it is not necessary to have your membership card to make an appointment or to receive care.

How do I select a dentist?

Simply note the dentist number for the Participating Dentist you would like to receive care from on your enrollment form. You may change dentists at any time by contacting your Member Service Specialist. The most current directory can be found at www.dentalhealthservices.com.

What if I have a dental emergency on the weekend, after office hours, or when I am out of town?

Your Selected Participating Dentist is expected to maintain 24-hour emergency availability. If for some reason you are unable to access your dentist or a Dental Health Services representative, you may seek emergency dental treatment from any dentist or healthcare provider practicing within the scope of their license. You will be reimbursed for the amount over your Copayment for dental services provided to treat Emergency Dental Condition.

What if I need to see a Specialist?

Your Selected Participating Dentist will coordinate your care to a Participating Specialist or other healthcare professional such as RN, ARNP operating within the scope of their license. Should you have any questions regarding this process, please contact your Member Services Specialists.

100 W Harrison St., Suite S440 | Seattle, WA 98119 | 800.637.6453 | dentalhealthservices.com

Enrollment Form

Dental Health Services Inc.

Last Name	First Name	M.I.	Social Security #
Address	City	State	Zip Code
E-mail Address	Home Phone	Work Phone	Birth Date

Preferred Spoken Language

Preferred Written Language

Sex: ☐ Male ☐ Female

Dentist Number – numeric code listed in directory.

Requested Effective Date

OFFICE USE ONLY

Group # Effective Date

Dependents to be covered*

Last Name	First Name	M.I.	Sex	Relationship	Birth Date

*Dependents include your spouse, domestic partner, and/or children under 26 years of age. Children 26 years of age and over are eligible only while the child is and continues to be both 1) incapable of sustaining employment by reason of developmental disability or physical challenge, and 2) is chiefly dependent upon the subscriber for support and maintenance, provided proof of incapacity and dependency is furnished to Dental Health Services within 31 days of such a request.

By submitting this form, I authorize my dentist to release any information regarding patient history to Dental Health Services, consulting professionals, or other entities designated or approved by Dental Health Services for the purpose of certifying, purchasing, providing, evaluating, or administering benefits. The authorization remains in effect until revoked by me in writing. I also certify that I am at least 18 years of age.

Signature Date

It is a crime to knowingly provide false, incomplete, or misleading information to Dental Health Services for the purpose of defrauding Dental Health Services. Penalties include imprisonment, fines, and denial of insurance benefits.

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND
(FOR WASHINGTON ACTIVES)

HMO BENEFITS - JULY 1, 2023 THROUGH JUNE 30, 2024

	KAISER (WASHINGTON)
PLAN DEDUCTIBLE (PER CALENDAR YR.)	$250 Individual / $500 Family
HOSPITAL SERVICES	$200 copayment per admit, deductible applies
PHYSICIAN OFFICE VISITS	Inpatient: No charge after deductible Outpatient: $35 copayment, deductible applies[1].
X-RAY AND LABORATORY SERVICES	No charge up to the first $500. Then you pay full cost until the deductible is met. At that point, the Plan will pay 100%.
PREVENTIVE AND WELLNESS CARE	Covered in full per KPWA Wellness Schedule.
CHIROPRACTIC	$35 copayment, deductible applies. Limited to 10 visits per calendar year.
MENTAL HEALTH CARE INPATIENT	Covered same as other inpatient services.
OUTPATIENT	Covered same as other outpatient services.
SUBSTANCE ABUSE INPATIENT	Covered same as other inpatient services.
OUTPATIENT	Covered same as other outpatient services.
AMBULANCE	Emergency ambulance transportation is covered at 80%.
OUTPATIENT SURGERY	$50 copayment, deductible applies.
SKILLED NURSING FACILITY	Limited to 60 days per calendar year. Deductible applies.
PRESCRIPTION DRUGS	Retail 30-day supply: $10 member copayment per generic prescription $30 member copayment per brand name prescription Mail Order 90-day supply: $20 member copayment per generic mail order prescription $60 member copayment for brand mail order prescription KPWA formulary drugs only.
ORGAN TRANSPLANTS	Unlimited, no waiting period. Outpatient: $35 member copayment, deductible applies. Inpatient: $200 copayment per admit, deductible applies
PHYSICAL AND OTHER THERAPIES	Covered up to 60 inpatient days per calendar year. $200 copayment per admit, deductible applies. Outpatient care requires a $35 member copayment per visit (limited to 60 visits per calendar year). Deductible applies.
DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC DEVICES	Covered at 80% for DME, prosthetic devices, orthopedic appliances, post-mastectomy bras, ostomy supplies and oxygen/oxygen equipment.
EMERGENCY CARE	$150 member copayment per visit. Deductible applies.

[1]Welcome Rider – First 4 office visits per calendar year are not subject to the deductible. You pay only the copayment. On subsequent visits, you will be responsible for the actual cost until the $250 deductible is met. After that point, the Plan will pay 100% after the copayment.

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.

COMPARISON OF BENEFITS DENTAL OPTIONS

WASHINGTON

	DENTAL HEALTH SERVICES	STANDARD
DEDUCTIBLE	No Deductible.	$50 per person ($150 family maximum).
MAXIMUM BENEFIT	No Maximum Benefit Limit.	$2.000 maximum benefit per person each calendar year. $1,000 lifetime maximum per person for Orthodontia.
SERVICES PERFORMED BY A PARTICIPATING GENERAL DENTIST	**YOU PAY**	**PLAN PAYS**
Diagnostic and Preventive		
Office Visit	$7	100% of covered expenses, deductible does not apply. Exams/ Cleanings once every 5 months, Bitewing X-rays once every 5 months and Full Mouth X-rays once every 36 months.
Prophylaxis	$12	
Full Mouth X-Rays	No Charge	
Failure to Cancel Appointment (within 24 hours)	Per office policy	
Emergency Visit After Hours	$40	
Sealants of Primary Teeth, as necessary	$5 per tooth	
Restorative		
Amalgam Fillings	$25-$60 (depending on number of surfaces and primary or permanent tooth)	90% of covered expenses.
Composite Fillings	$47-$105 (depending on number of surfaces and location of tooth)	
Endodontics		
Root Canal Therapy		90% of covered expenses.
Anterior	$275	
Bicuspid	$370	
Molar	$575	
Periodontics		
Deep scaling and root planing	$45-$70	90% of covered expenses.
Osseous surgery	$350-$500	
Crowns and Bridges		
Porcelain crown	$475 + any upgrade charges	70% of covered expenses.
Porcelain with metal crown	$475 + any upgrade charges	
Cast metal crown	$475 + any upgrade charges	
Prosthodontics		
Complete denture (upper or lower)	$700	70% of covered expenses.
Partial denture	$675-$775	
Office reline (cold cure)	$110-$170	
Oral Surgery		
Single extraction	$60	90% of covered expenses.
Impaction	$135-$265 (depending on degree of impaction)	
Local anesthetics	No Charge	
Orthodontia		
Diagnostic workup	$40	50% of covered expenses up to a maximum payment of $1,000. Deductible does not apply.
Comprehensive orthodontic treatment	$3,395 (dependent children up to age 19) $3,495 (adult)	
Max Builder Program	Not Applicable	Yes

This comparison is only a summary of the coverages actually provided by each of the above specified Benefit Programs. Not all exclusions and limitations of benefit coverages have been included and may vary from Plan to Plan. The contents of this comparison are not to be construed or accepted as a substitute for the provisions of each master policy or contract.

STANDARD – MAX BUILDER PROGRAM

The Standard dental plans include a feature that allow members to carryover part of their unused annual maximum. You can earn dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, member earning dental rewards who submits a claim for services received through the dental network earns an extra reward, called the PPO Bonus. Members and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If you do not submit a dental claim during a benefit year, all accumulated rewards are lost. But you can begin earning rewards again the very next year.

Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$400	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$200	Additional bonus is earned if the member sees a network provider
Maximum Carryover	$1,200	Maximum possible accumulation for Max Builder and PPO Bonus combined

PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

Date: **May 2023**
To: **Kaiser Foundation Health Plan of Washington 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 Foundation Health Plan of Washington.** 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.

7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566 • P O Box 2510 • San Ramon, CA 94583
Phone 925-398-7056 • Toll Free 844-403-0032 • Fax 925-462-0108

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, www.kp.org/plandocuments or call 1-888-901-4636 (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 1-888-901-4636 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 Individual / $500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	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 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?	$2,000 Individual / $4,000 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, balance-billing charges, 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 1-888-901-4636 (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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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	$35 / visit	Not covered	Deductible and coinsurance do not apply to any combination of first 4 outpatient visits / year (preventive care does not count towards visit limit).
	Specialist visit	$35 / visit	Not covered	None
	Preventive care/screening/ immunization	No charge, deductible does not apply.	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	No charge up to a $500 allowance (Diagnostic test & Imaging combined) / year. After allowance coinsurance will apply.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	No charge up to a $500 allowance (Diagnostic test & Imaging combined) / year. After allowance coinsurance will apply. Preauthorization required or will not be covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Preferred generic drugs	$10 (retail); 2x retail cost share (mail order) / prescription, deductible does not apply.	Not covered	Up to a 90-day supply (retail / mail order). Subject to formulary guidelines.
	Preferred brand drugs	$30 (retail); 2x retail cost share (mail order) / prescription, deductible does not apply.	Not covered	Up to a 90-day supply (retail / mail order). Subject to formulary guidelines.
	Non-preferred drugs	Applicable Preferred generic or Preferred brand cost shares apply.	Not covered	Up to a 90-day supply (retail / mail order). Subject to formulary guidelines , when approved through the exception process..
	Specialty drugs	Applicable Preferred generic or Preferred brand cost shares apply.	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 / visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need immediate medical attention	Emergency room care	$150 / visit	$150 / visit	You must notify Kaiser Permanente within 24 hours if admitted to a Non-network provider; limited to initial emergency only. Copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance, deductible does not apply.	20% coinsurance , deductible does not apply.	None
	Urgent care	$35 / visit	$150 / visit	Non-network providers covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 / admission	Not covered	Preauthorization required or will not be covered.
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee. Preauthorization required or will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 / visit	Not covered	None
	Inpatient services	$200 / admission	Not covered	Preauthorization required or will not be covered.
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. You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	$200 / admission	Not covered	You must notify Kaiser Permanente within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.
If you need help recovering or have other special health needs	Home health care	No charge, deductible does not apply.	Not covered	Preauthorization required or will not be covered.
	Rehabilitation services	Outpatient: $35 / visit Inpatient: $200 / admission	Not covered	Combined with Habilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered.
	Habilitation services	Outpatient: $35 / visit Inpatient: $200 / admission	Not covered	Combined with Rehabilitation services: Outpatient: 60 visit limit / year. Inpatient: 60-day limit / year, preauthorization required or will not be covered.
	Skilled nursing care	No charge	Not covered	60-day limit / year. Preauthorization required or will not be covered.
	Durable medical equipment	20% coinsurance, deductible does not apply.	Not covered	Subject to formulary guidelines. Preauthorization required or will not be covered.
	Hospice services	No charge, deductible does not apply.	Not covered	Preauthorization required or will not be covered.
If your child needs dental or eye care	Children's eye exam	$35 / visit for refractive exam, deductible does not apply.	Not covered	Limited to 1 exam / 12 months
	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.)

- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care (Adult and child)
- Hearing aids
- Infertility treatment
- 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 (12 visit limit / year)	• Chiropractic care (10 visit limit / year)	• 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	1-888-901-4636 (TTY: 711) or www.kp.org
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov.
Washington Department of Insurance	1-800-562-6900 or www.insurance.wa.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 1-888-901-4636 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4636 (TTY: 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-901-4636 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4636 (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	$250
Specialist copayment	$35
Hospital (facility) copayment	$200
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	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$470**

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 cost sharing copayment	$35
Hospital (facility) copayment	$200
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	$250
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,150**

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

The plan's overall deductible	$250
Specialist cost sharing copayment	$35
Hospital (facility) copayment	$200
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	$250
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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

PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

Important Employee Benefit Program Notices

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.

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.

THIS INFORMATION DOES NOT APPLY TO RETIREES AND DEPENDENTS WHO ARE COVERED UNDER A MEDICARE ADVANTAGE PLAN.

7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566 • P O Box 2510 • San Ramon, CA 94583
Phone 925-398-7056 • Toll Free 844-403-0032 • Fax 925-462-0108

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 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 Trust Fund Office at (925) 398-7056 Trust Fund Office at (925) 398-7056.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

The Kaiser medical plans 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, Kaiser 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 Kaiser.

Direct Access to OB/GYN Providers:

You do not need prior authorization (pre-approval) from the Trust Fund or Kaiser 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 Kaiser.

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, 2023. 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)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, 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 Service
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)

7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566 • P O Box 2510 • San Ramon, CA 94583
Phone 925-398-7056 • Toll Free 844-403-0032 • Fax 925-462-0108

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: _____

SSN: _____ Relationship: _____

Address: _____ 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)* _____
DATE OF MARRIAGE

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.