PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

New Member Enrollment Package Contents - Washington

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

Enclosed please find:

Health Care Plan Document

This book contains the rules of the Plan and a description of the benefits available to you and your dependents. **It is very important that you and your spouse read the information regarding your rights to possibly continuing your health care coverage if it is terminated. These are known as your "COBRA Rights" and are explained in the Health Care Plan Document and a notice contained in this package.**

Enrollment Form

This is required for all participants and must be **completed** and returned to the address below as soon as possible. This will stop any delay in processing claims because of missing information.

Coordination of Benefits Form

This is required for all participants and needs to be completely filled out if you or any of your dependents have other healthcare coverage. *If you and/or dependents **do not** have other insurance coverage, please check the indicator box and sign/date the bottom of the page under "Member Statement" and return to the Trust Fund Office.*

Notice of the Privacy Practices (HIPAA) and Authorization Form

Please read the enclosed HIPAA Privacy Notice, which explains your rights, and how and when the medical information may be disclosed. Effective April 2003, you will no longer receive health care information over the phone for any member of your family other than yourself or your minor child (under age 18), **unless a signed authorization form is on file at this office. Please complete and sign the enclosed Authorization for Release of Protected Health Information Form and return it to the Fund Office.**

Notices of COBRA Continuation Coverage Rights

Please read this information. This notice contains important information about your rights to COBRA Continuation Coverage, which is a temporary extension of coverage under the Plan.

Dental Plan

Dental Benefits are provided through Dental Health Services or Standard Dental to all employees who do not opt out of dental coverage. Please review your Summary Plan Description to find the benefit coverage available to you and the exclusions that apply to the Plan.

-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

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Vision Plan

Vision Benefits are provided through Vision Service Plan ("VSP") to all employees who do not opt out of dental and vision coverage. Please see the enclosed benefit summary sheet regarding VSP.

Identification Cards

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

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

PLEASE RETURN ALL FORMS TO:

PACIFIC COAST SHIPYARDS METAL TRADES
HEALTH & WELFARE TRUST FUND
P.O. BOX 2510
SAN RAMON, CA 94583

PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

NEW MEMBER PACKET CHECK LIST

FORMS TO BE RETURNED TO THE TRUST FUND OFFICE:

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

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

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PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

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

ENROLLMENT FORM

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

EMPLOYEE'S FULL NAME:_____ SSN:_____

ADDRESS:_____ CITY: _____

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

PHONE NUMBER: (_____)_____ GENDER: (Mark One) Male_____ Female _____

MEDICAL PLAN: WASHINGTON (Provided By):	**DENTAL (CHOOSE ONE):**	**VISION (Provided By):**
☐ KAISER PERMANENTE (**Group** # 25900)	☐ DENTAL HEALTH SERVICES ☐ 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)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:
Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SSN	GENDER

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:** _____

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Coordination of Benefits

☐ **If you and/or your dependents DO NOT have any other insurance coverage, please check this box and sign/date at the bottom of the page under "Member Statement" (section E)**

Member Information: Name: _____ SSN or ID: _____

Other Insured Person (Policy Holder):

Name: _____ Date of Birth: _____ Relationship to Member: _____

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

OTHER HEALTH COVERAGE INFORMATION

A Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Medical Carrier:_____Phone#:_____
Effective Date:_____ Policy/Group Number:_____

B Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Dental Carrier:_____Phone#:_____
Effective Date:_____ Policy/Group Number:_____

C Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Vision Carrier:_____Phone#:_____
Effective Date:_____ Policy/Group Number:_____

D Does this plan include **Prescription** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Prescription Carrier:_____Phone#:_____
Effective Date:_____ Policy/Group Number:_____

List all covered dependents:

1._____ Social Security#: _____-_____-_____
2._____ Social Security#: _____-_____-_____
3._____ Social Security#: _____-_____-_____
4._____ Social Security#: _____-_____-_____
5._____ Social Security#: _____-_____-_____

Fill out this section only if your children have health care coverage in addition to the above because of divorce, separation, court order or marriage work related group coverage.

Is there a court order that determines responsibility for health care coverage or custody? □Yes or □ No

If yes, attach a copy of the sections that apply to health care responsibility and/or custody arrangements

Name of person responsible for child's heath care coverage?		Employer	Birthdate
Insurance company name	Insurance company city	State	Phone number
Enrollee ID/policy number	Group number	Effective date	Cancellation date (if applicable)

Custody Insurance:

1. Are you divorced or separated from the parent of any dependent on this policy listed above? □Yes or □ No
   - If Yes (continue) If No (skip to section E) ***(Indicate which child by marking appropriate circle)***
2. Does one parent/guardian have full custody of the child(ren)? □Yes or □ No (If yes, which child)? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5
   - Parent: _____ Date: _____
3. Is one parent required by court decree to provide health insurance for the children? □Yes or □ No ○ 1 ○ 2 ○ 3 ○ 4 ○ 5
   - Parent: _____ Date: _____

****If court decree is present, please provide an ATTACHMENT to the back of this copy****

Medicare/Medicaid (if applicable)	Are you or anyone else on your policy covered by Medicare or Medicaid? □Yes or □ No	Medicare Policy holder name	Medicare HIC number
Is the covered person retired? □Yes or □ No		Is the Medicare coverage because of? □Age or □ Disability	

****** Medicare coverage includes: (check all that apply, followed by effective date) ******

Type: A □ B □ C □ D □ Effective date: A)_____ B)_____ C)_____ D)_____

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

E	**Signature**		Telephone Number:	Date:

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Instructions for completing the

Authorization for Release of Protected Health Information

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

Member Section /Retiree Section

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

   OR

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

Spouse Section

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

   OR

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

Dependent(s) over the age of 18 Section

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

   OR

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

-OVER-

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

Pacific Coast Shipyards Metal Trades Trust Fund
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

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

Signature of Member_____**Date Signed:** _____

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

Signature of Member_____**Date Signed**: _____

SPOUSE SECTION

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse_____ **Date Signed**: _____

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

Signature of Spouse_____ **Date Signed**: _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent_____**Date Signed**: _____

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

Signature of Dependent_____**Date Signed**: _____

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

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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)

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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.

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

DENTAL ENROLLMENT FORMS

CHOOSE ONE DENTAL CARRIER ONLY

Enclosed are forms for Standard Dental and Dental Health Services.

You may enroll in only **ONE** of these plans.

Please complete **only** the dental enrollment form for the carrier of your choice. Return that enrollment form along with your completed medical enrollment form and your beneficiary designation form in the envelope provided.

If you wish to DECLINE enrollment for dental and vision coverage please complete the enclosed form stating such.

Please contact the trust fund office if you have any questions.

Thank you,
P.C.S.M.T.T.F.

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

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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.**

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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

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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

Request to DECLINE DENTAL Coverage

☐ **Check this box only if you wish to *Decline* your dental and vision benefits.**

Participants that decline Dental and Vision benefits are **REQUIRED** to elect the DMO option for the first 2 years upon re-enrollment.

I understand that I am not eligible for re-enrollment under the Dental PPO plan until the end of the two-year DMO enrollment.

Signed _____ Print Name _____

Mailing Address (Street or P.O. Box) _____

City, State, Zip Code _____

Home Phone Number _____ Work Phone Number _____

Social Security Number _____ Dated _____

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

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A LOOK AT YOUR VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND AND VSP.

VSP Vision care for life

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

PREMIER PROGRAM

Like shopping online? Go to **eyeconic.com** and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

GET YOUR PERFECT PAIR

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

\+ UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

USING YOUR BENEFIT IS EASY!

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

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

YOUR VSP VISION BENEFITS SUMMARY

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:

VSP Choice

EFFECTIVE DATE:

07/01/2020

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$25 for exam and glasses	Every 12 months
PRESCRIPTION GLASSES			
FRAME	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance	Combined with exam	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
DIABETIC EYECARE PLUS PROGRAM℠	• Retinal screening for members with diabetes • Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor details.	$0 $5 per exam	As needed
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

SELF-PAYMENT ELECTION FORM
(MUST be returned to the Trust Fund Office with Payment)

Name:_____ Soc Sec No:_____

Telephone Number:_____ Date of Birth:_____

_____ _____
Name of Applicant for Continuation Relationship to Employee

_____ _____
Applicant's Street Address or P.O. Box Number Date of Qualifying Event

_____
Applicant's City/State/Zip Code

I elect: Self-payment Coverage for **a maximum payment of $7,000.00 (12 MONTH PERIOD)**, at the end of which if I have not regained eligibility, I have the option of electing COBRA continuation.

The SELF-Payment amount is equal to the "Cost of Coverage" based on elected Medical & Dental carriers. Furthermore, you have the option of using the dollar bank balance as partial payment towards the continuation of coverage. The amount due reflected on the enclosed self-payment notice is your current cost of coverage less your dollar bank balance.

If you wish to make payments for the continuation of coverage based on the "cost of coverage", you are required to complete & return this form to the Trust Fund office along with your payment.

I understand that I must notify the Trust Fund Office immediately when anyone under continuation coverage first becomes covered under Medicare or another Group health plan. I also must notify the Trust Fund Office within 60 days after the employee divorces or a dependent child loses dependent status.

I also understand that is Social Security determines me or a dependent to be disabled at the time my employment terminated or hours were cut back, the disabled person is entitled to extend coverage an additional 11 months beyond the 18 months, provided that I notify the Trust Fund Office within 60 days of the Social Security determination and before the end of the first 18 months of coverage.

_____ _____
Signature of Applicant Date

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

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PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

Notice of COBRA Continuation Coverage Rights

Introduction

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

The Plan administrator is BeneSys Administrators (the "Fund Office") located at P.O. Box 2510, San Ramon, CA 94583. You can call the office at 925-398-7056 or 844-403-0032. The Plan administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

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

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

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

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

1. Your spouse dies;

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

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

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

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

For other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You may send written notice of the event to: Pacific Coast Shipyards Metal Trades Trust Fund, P.O. Box 2510, San Ramon, CA 94583, or you can report a qualifying event by calling the Fund Office at 925-398-7056 or 844-403-0032 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation to the Fund Office at: P.O. Box 2510, San Ramon, CA 94583.

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

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

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

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent along with a copy of the Social Security Administration's determination to the Pacific Coast Shipyards Metal Trades Trust Fund, P.O. Box 2510, San Ramon, CA 94583.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Pacific Coast Shipyards Metal Trades Trust Fund, P.O. Box 2510, San Ramon, CA 94583, or you can report a qualifying event by calling the Fund Office at 925-398-7056 or 844-403-0032 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation, or Medicare Card to the Fund Office at: P.O. Box 2510, San Ramon, CA 94583.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Fund Office by calling 925-398-7056 or 844-403-0032. Written correspondence should be sent to: Pacific Coast Shipyards Metal Trades Trust Fund, P.O. Box 2510, San Ramon, CA 94583. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

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

PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

PRIVACY PRACTICES NOTICE

July 2016

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

Introduction. Health plans are required to protect the confidentiality of health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes the Pacific Coast Shipyards Metal Trades Trust Fund Health and Welfare Plan's practices and policies with respect to your confidential health information. This notice does not address the privacy practices and policies of your health care providers (doctors, HMOs, etc.).

I. RESPONSIBILITIES OF THE PLAN

A. The Pacific Coast Shipyards Metal Trades Trust Fund is required by law to:

1. protect the privacy of your health information;

2. provide you with this notice describing our legal duties to keep your health information private, as well as your rights to access your health information;

3. notify affected individuals following a breach of unsecured protected health information; and

4. follow the terms set out in this notice for as long as it is in effect.

B. The Plan reserves the right to change the terms of this notice and make new provisions for the protection of your health information. However, if any change is made to the way your health information is used or disclosed, the Plan will notify you by sending you a new privacy practices notice to replace this one, or by sending you information about the change and how to obtain a copy of the Plan's new privacy practices notice.

II. USES AND DISCLOSURES

A. The Plan is REQUIRED by law to disclose your health information, even without your written authorization, in the following circumstances:

1. To you, if you request it.

2. When required by the Secretary of the Department of Health and Human Services to determine whether the Plan has adequately protected the privacy of your medical records.

B. The Plan is ALLOWED by law to use or disclose your health information without your written authorization for the following purposes. The Plan is prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes.

1. Treatment. The Plan may disclose information to the doctors and hospitals that you have gone to for health care. *For example, if you are unable to provide your medical history to an emergency room doctor, the Plan may disclose to the doctor the types of prescription drugs you currently take.*

2. Payment for health care services. The Plan may use and disclose information so that claims for health care treatment, services and supplies you receive may be paid according to the Plan's terms. *For example, the Plan may need to know what treatment or supplies you received from your doctor, before it can reimburse your doctor for the services.*

3. Health care operations. The Plan may need to use some of your health information for its own internal purposes. *For example, the Plan may use some of your health information to conduct compliance audits, or to determine what coverage the Plan should provide.*

4. Reports to the Plan sponsor. The Plan may disclose information to the Board of Trustees so they can carry out their Plan-related administrative functions. The Plan's documents have been amended to ensure that the Board protects the privacy of such information.

5. Disclosures to the Plan's Business Associates. The Plan uses Business Associates to provide certain services to the Plan, such as administrative, legal, accounting, or health care services. The Plan may disclose health information to a Business Associate, where the Business Associate has agreed in writing to appropriately safeguard that information.

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

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

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

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

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

11. For some law enforcement activities, such as complying with a law enforcement official's request for limited information to identify a suspect or missing person.

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

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

14. For organ, eye or tissue donation purposes.

15. To comply with workers' compensation laws.

16. For the creation, renewal or replacement of a contract of health insurance or health benefits. If the contract is not created, renewed or replaced, your health information will not be used for any other purpose, except as required by law.

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

18. For other uses required by law.

C. The Plan is ALLOWED to disclose your health information in the following circumstances ONLY if you have given the Plan a valid authorization:

1. Any use or disclosure of psychotherapy notes, except in certain situations as specified by law;

2. For marketing by the Plan, except for face-to-face communications and gifts of nominal value. However, this Plan does no marketing; and

3. For a sale of protected health information. However, this Plan does not sell protected health information.

D. The Plan is ALLOWED to disclose your health information in the following circumstances ONLY if you have been given the opportunity to prohibit or restrict the use or disclosure, or if you are not present or are incapable of making medical decisions, and the Plan believes it is in your best interest:

1. For use in a directory of patients in a health care facility.

2. To your family members, friends or other person designated by you, if they are participating in your treatment or making decisions with you or on your behalf.

3. To notify your family members, personal representative or another person responsible for your care of your general condition, location or death.

E. The Plan is NOT ALLOWED to use or disclose your health information without a written authorization from you for any purpose other than the ones listed in this notice. If you authorize a disclosure, you have the right to revoke the authorization. The revocation must be in writing.

III. YOUR RIGHTS

You have the right to:

A. Request restrictions on the Plan's use and disclosure of your information to carry out treatment, payment or health care operations. You may also request restrictions on the use and disclosure to family members, relatives, friends or other persons identified by you who are involved in your care. However, the Plan is not required to agree to your requested restriction.

B. Receive confidential communications regarding your health information by reasonable alternative means or at reasonable alternative locations, if you let the Plan know that the disclosure of all or part of that information could endanger you. The Plan may require that you provide it with information on how payment, if any, will be handled and may require that you provide it with an alternative address or way of contacting you.

C. Inspect and copy your health information;

D. Amend your health information, if it is incomplete or incorrect;

E. Receive an accounting (list) of all of the disclosures of your health information made by the Plan, other than those allowed under the regulations, during the past six years;

F. Obtain a paper copy of this notice, if you have received this notice electronically.

In order to exercise any of these rights, you should contact the Plan's privacy officer, at the address and phone number listed in Section V below. The privacy officer will explain the Plan's procedure for exercising any of your rights listed above. You may be required to submit your request to the Plan in writing.

IV. **COMPLAINTS**

A. You have the right to file a complaint with the Plan if you believe that the Plan has violated your privacy rights as described in this notice. To file a complaint with the Plan, send a written complaint, including all of the information relevant to your complaint, to the Plan Administration Office at the following address:

Pacific Coast Shipyards Metal Trades Trust Fund
c/o BeneSys Administrators
Attn: Privacy Officer
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

B. You also have the right to file a complaint with the Secretary of Health and Human Services if you believe that the Plan has violated your privacy rights, as described in this notice.

C. The Plan will not retaliate against you for filing a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

V. CONTACT INFORMATION

A. You may obtain more information regarding this notice and the privacy practices of the Plan by contacting:

Privacy Officer
Pacific Coast Shipyards Metal Trades Trust Fund
c/o BeneSys Administrators
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566
(925) 398-7056 or (844) 403-0032

VI. FEDERAL REGULATIONS

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

VII. THIS NOTICE IS EFFECTIVE AS OF SEPTEMBER 23, 2013.

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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

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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)