

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

May 2024

TO: ACTIVE PARTICIPANTS IN CALIFORNIA

RE: JULY 1, 2024 OPEN ENROLLMENT – MEDICAL AND DENTAL COVERAGE

The Board of Trustees has completed negotiations with the HMO and dental carrier for rates effective July 1, 2024, through June 30, 2025. The enclosed page shows the charge-off rates effective July 1, 2024, for each combination of medical and dental options.

The Board had difficult negotiations with Kaiser resulting in higher annual medical costs. Due to the result of these negotiations, the Trustees have elected to increase the annual subsidy in California by \$259 from \$300 to \$559 effective July 1, 2024, to help with the increased costs of medical care.

OPEN ENROLLMENT

If you would like to change your coverage effective July 1, 2024, please complete the enclosed Change of Coverage Request form *as well as the necessary enrollment forms*. **You will not be allowed to change your coverage unless you return the completed HMO or dental plan enrollment application to the Fund Office by Wednesday, June 19, 2024.** Completed forms may be faxed to 925-462-0108.

MEDICAL

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

DENTAL

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

VISION

There are no changes to the vision plan effective July 1, 2024.

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

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

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

Pacific Coast Shipyards Metal Trades Trust Fund
Revised Cost of Coverage / Dollar Bank Charge-off
July 2024 California

OPTION 1		OPTION 2	
Kaiser Medical	\$1,981.34	Kaiser Medical	\$1,981.34
Standard Dental	101.87		
Vision	5.15		
Life insurance	<u>4.50</u>	Life insurance	<u>4.50</u>
Actual Cost of Benefits	\$2,092.86	Actual Cost of Benefits	\$1,985.84
Trust Fund Subsidy *	\$559	Trust Fund Subsidy *	\$559
Your Charge-off	\$1,534	Your Charge-off	\$1,427

* At the May 1, 2023 meeting, the Board voted to increase the Trust Fund Subsidy from \$200 to \$300 effective July 1, 2023.
Please note that the Trustees may reduce or eliminate the subsidy at any time for any reason.

**Pacific Coast Shipyards Metal Trades Trust Fund
Change of Coverage Request – CALIFORNIA
Effective July 1, 2024**

MEDICAL

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

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

I understand that this Change of Coverage Request form is not an HMO or dental plan application and that any change in my benefits will become effective July 1, 2024 only if I complete the actual application for the HMO or dental plan and return it to the Trust Fund office by **June 19, 2024**.

Signed: _____

Print Name: _____

Address: _____

Dated: _____

Home Phone: _____

Social Security #: _____

Work Phone: _____

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

ENROLLMENT FORM

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

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 _____

<u>MEDICAL PLAN: CALIFORNIA (CHOOSE ONE):</u> <input type="checkbox"/> KAISER PERMANENTE HMO PLAN (<u>Active</u> Grp# 8012-0) <input type="checkbox"/> KAISER PERMANENTE HMO PLAN (<u>Retiree</u> Grp# 8012-1) **If enrolling in Kaiser you must also sign the Kaiser Arbitration Agreement below**	<u>DENTAL (Provided By):</u> <input type="checkbox"/> STANDARD DENTAL (PPO) **Complete enclosed Dental Plan Enrollment Form or Declination of Coverage Form. **	<u>VISION (Provided By):</u> VISION SERVICE PLAN (VSP)
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NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

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

FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Signature Required for Kaiser Permanente Plan

Date

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

MEMBER SIGNATURE _____ DATE: _____

enrollment/change/waiver Group Insurance Form

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



Policy and Div. # 160- _____ Cert. # _____	COBRA: If individual is a continuee: _____	Qualifying Event _____	Date of Event _____
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Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ To terminate all coverages

Employee Information

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

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

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

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

Street address _____ City _____ State _____ ZIP _____

E-mail address (limit of 60 characters) _____

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

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

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

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

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

X _____ Employee Signature (do not print)	_____ Date	X _____ Policyholder Signature (do not print)	_____ Date
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In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date _____	Effective Date	Class	Dep. Code
Dependent late entrant date _____			

2 to change

☐ **Name Change** New Name _____ Old Name _____

☐ **Add Dependent Coverage**

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

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

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

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

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

☐ Other (please explain) _____

3 to waive

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

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

because _____

Name of insurance company and employer of dependent _____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

tips for filling out this form

To Enroll

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

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

To Change

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

Imaging

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

Do:

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

Don't:

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

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

HMO BENEFITS - JULY 1, 2024 THROUGH JUNE 30, 2025

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

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

Date: May 2024
To: Kaiser of California Active and Non-Medicare Retiree Participants and Dependents (including COBRA beneficiaries)
From: Board of Trustees
Subject: Summary of Benefits and Coverage (SBC)

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

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

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

What the SBC Contains

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

When You Will Receive an SBC

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

60-Day Notice for Material Modification of Plan Benefits

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

* * * * *

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



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$3,000 Individual / \$6,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes, but you may self-refer to certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 / visit	Not Covered	None
	Specialist visit	\$50 / visit	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	\$100 / procedure	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	Retail: \$15 / prescription ; Mail order: \$30 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs (Tier 2)	Retail: \$35 / prescription ; Mail order: \$70 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Non-preferred brand drugs (Tier 2)	Retail: \$35 / prescription ; Mail order: \$70 / prescription	Not Covered	The cost sharing for non-preferred brand drugs under this plan aligns with the cost sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	30% coinsurance up to \$250 / prescription	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	\$150 / visit	\$150 / visit	None
	Emergency medical transportation	\$150 / trip	\$150 / trip	None
	Urgent care	\$40 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: \$40 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 / day	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 / individual visit. No Charge for other outpatient services	Not Covered	Mental / Behavioral Health: \$20 / group visit; Substance Abuse: \$5 / group visit.
	Inpatient services	\$500 / day	Not Covered	None
If you are pregnant	Office visits	No Charge	Not covered	Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	Professional services are included in the Facility services.
	Childbirth/delivery facility services	\$500 / day	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	2-hour limit / visit, 3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient: \$500 / day; Outpatient: \$40 / visit	Not Covered	None
	Habilitation services	\$40 / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	100 day limit / benefit period.
	Durable medical equipment	50% coinsurance	Not Covered	Requires prior authorization.
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Children's glasses Chiropractic care Cosmetic surgery Dental Care (Adult & Child) 	<ul style="list-style-type: none"> Hearing aids Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Acupuncture (plan provider referred) Bariatric surgery 	<ul style="list-style-type: none"> Infertility treatment 	<ul style="list-style-type: none"> Routine eye care (Adult)

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

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

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

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

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

Language Access Services:

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

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

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby

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

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

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Peg would pay is	\$650

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,400

Mia's Simple Fracture

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

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

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$520

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

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
 - ◆ Qualified sign language interpreters
 - ◆ Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
 - ◆ Qualified interpreters
 - ◆ Information written in other languages

If you need these services, call our Member Service Contact Center at **1 800-464-4000 (TTY 711)**, 24 hours a day, 7 days a week (except closed holidays). If you cannot hear or speak well, please call **711**.

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You may also speak with a Member Services representative about the options that apply to you. Please call Member Services if you need help filing a grievance.

You may submit a discrimination grievance in the following ways:

- **By phone:** Call member services at **1-800-464-4000 (TTY 711)** 24 hours a day, 7 days a week (except closed holidays)
- **By mail:** Call us at **1-800-464-4000 (TTY 711)** and ask to have a form sent to you
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at kp.org

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

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

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

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

- **By phone:** Call DHCS Office of Civil Rights at 916-440-7370 (TTY 711)
- **By mail:** Fill out a complaint form or send a letter to:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call 1-800-368-1019 (TTY 711 or 1-800-537-7697)
- **By mail:** Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>

- **Online:** Visit the Office of Civil Rights Complaint Portal at:
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

Aviso de no discriminación

La discriminación es ilegal. Kaiser Permanente cumple con las leyes de los derechos civiles federales y estatales.

Kaiser Permanente no discrimina ilícitamente, excluye ni trata a ninguna persona de forma distinta por motivos de edad, raza, identificación de grupo étnico, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, género, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, condición médica, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

Kaiser Permanente ofrece los siguientes servicios:

- Ayuda y servicios sin costo a personas con discapacidades para que puedan comunicarse mejor con nosotros, como lo siguiente:
 - ◆ intérpretes calificados de lenguaje de señas,
 - ◆ información escrita en otros formatos (braille, impresión en letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Servicios de idiomas sin costo a las personas cuya lengua materna no es el inglés, como:
 - ◆ intérpretes calificados,
 - ◆ información escrita en otros idiomas.

Si necesita nuestros servicios, llame a nuestra Central de Llamadas de Servicio a los Miembros al **1-800-464-4000 (TTY 711)** las 24 horas del día, los 7 días de la semana (excepto los días festivos). Si tiene deficiencias auditivas o del habla, llame al **711**.

Este documento estará disponible en braille, letra grande, casete de audio o en formato electrónico a solicitud. Para obtener una copia en uno de estos formatos alternativos o en otro formato, llame a nuestra Central de Llamadas de Servicio a los Miembros y solicite el formato que necesita.

Cómo presentar una queja ante Kaiser Permanente

Usted puede presentar una queja por discriminación ante Kaiser Permanente si siente que no le hemos ofrecido estos servicios o lo hemos discriminado ilícitamente de otra forma. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)* para obtener más información. También puede hablar con un representante de Servicio a los Miembros sobre las opciones que se apliquen a su caso. Llame a Servicio a los Miembros si necesita ayuda para presentar una queja.

Puede presentar una queja por discriminación de las siguientes maneras:

- **Por teléfono:** llame a Servicio a los Miembros al **1 800-464-4000 (TTY 711)**, las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- **Por correo postal:** llámenos al **1 800-464-4000 (TTY 711)** y pida que se le envíe un formulario.
- **En persona:** llene un formulario de Queja o reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte su directorio de proveedores en kp.org/facilities [cambie el idioma a español] para obtener las direcciones).
- **En línea:** utilice el formulario en línea en nuestro sitio web en kp.org/espanol.

También puede comunicarse directamente con el coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente a la siguiente dirección:

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

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California *(Solo para beneficiarios de Medi-Cal)*

También puede presentar una queja sobre derechos civiles ante la Oficina de Derechos Civiles (Office of Civil Rights) del Departamento de Servicios de Atención Médica de California (California Department of Health Care Services) por escrito, por teléfono o por correo electrónico:

- **Por teléfono:** llame a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica (Department of Health Care Services, DHCS) al **916-440-7370** (TTY **711**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights

P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Los formularios de queja están disponibles en:

http://www.dhcs.ca.gov/Pages/Language_Access.aspx (en inglés).

- **En línea:** envíe un correo electrónico a CivilRights@dhcs.ca.gov.

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU.

Puede presentar una queja por discriminación ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. (U.S. Department of Health and Human Services). Puede presentar su queja por escrito, por teléfono o en línea:

- **Por teléfono:** llame al **1-800-368-1019** (TTY **711** o al **1-800-537-7697**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Los formularios de quejas están disponibles en

<http://www.hhs.gov/ocr/office/file/index.html> (en inglés).

- **En línea:** visite el Portal de quejas de la Oficina de Derechos Civiles en: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> (en inglés).

反歧視聲明

歧視是違反法律的行為。Kaiser Permanente 遵守州政府與聯邦政府的民權法。

Kaiser Permanente 不因年齡、人種、族群認同、膚色、原國籍、文化背景、祖籍、宗教、生理性別、社會性別、性認同、性表現、性取向、婚姻狀況、身體或精神殘障、病況、付款來源、遺傳資訊、公民身份、母語或移民身份而非法歧視、排斥或差別對待任何人。

Kaiser Permanente 提供下列服務：

- 為殘障人士提供免費協助與服務以幫助其更好地與我們溝通，例如：
 - ◆ 合格手語翻譯員
 - ◆ 其他格式的書面資訊（盲文版、大字版、語音版、通用電子格式及其他格式）
- 為母語非英語的人士提供免費語言服務，例如：
 - ◆ 合格口譯員
 - ◆ 其他語言的書面資訊

如果您需要上述服務，請打電話 1-800-464-4000 (TTY 711) 給會員服務聯絡中心，每週 7 天，每天 24 小時（節假日除外）。如果您有聽力或語言困難，請打電話 711。

若您提出要求，我們可為您提供本文件的盲文版、大字版、錄音卡帶或電子格式。如要得到上述一種替代格式或其他格式的版本，請打電話給會員服務聯絡中心並索取您需要的格式。

如何向 Kaiser Permanente 投訴

如果您認為我們未能提供上述服務或有其他形式的非法歧視行為，您可向 Kaiser Permanente 提出歧視投訴。請參閱您的《承保範圍說明書》(*Evidence of Coverage*) 或《保險證明》(*Certificate of Insurance*) 瞭解詳情。您也可以向會員服務部代表諮詢適用於您的選項。如果您在投訴時需要協助，請打電話給會員服務部。

您可透過下列方式投訴歧視：

- **電話：** 打電話 1 800-464-4000 (TTY 711) 聯絡會員服務部，每週 7 天，每天 24 小時（節假日除外）
- **郵寄：** 打電話 1 800-464-4000 (TTY 711) 與我們聯絡，要求將投訴表寄給您
- **親自提出：** 在保險計劃下屬設施的會員服務辦公室填寫投訴或索賠／申請表（請在 kp.org/facilities 網站的保健業者名錄上查詢地址）
- **線上：** 使用 kp.org 網站上的線上表格

您也可直接與 Kaiser Permanente 民權事務協調員聯絡，地址如下：

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

如何向加州保健服務部民權辦公室投訴（僅限 *Medi-Cal* 受益人）

您也可透過書面方式、電話或電子郵件向加州保健服務部民權辦公室提出民權投訴：

- **電話：**打電話 916-440-7370 (TTY 711) 聯絡保健服務部 (DHCS) 民權辦公室
- **郵寄：**填寫投訴表或寄信至：

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

您可在網站上 http://www.dhcs.ca.gov/Pages/Language_Access.aspx 取得投訴表

- **線上：**發送電子郵件至 CivilRights@dhcs.ca.gov

如何向美國健康與民眾服務部民權辦公室投訴

您可向美國健康與民眾服務部民權辦公室提出歧視投訴。您可透過書面、電話或線上提出投訴：

- **電話：**打電話 1-800-368-1019（TTY 711 或 1-800-537-7697）
- **郵寄：**填寫投訴表或寄信至：

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

您可在網站上取得投訴表：

<http://www.hhs.gov/ocr/office/file/index.html> 取得投訴表

- **郵寄：**訪問民權辦公室投訴入口網站：
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>。

Thông Báo Không Phân Biệt Đối Xử

Phân biệt đối xử là trái với pháp luật. Kaiser Permanente tuân thủ các luật dân quyền của Tiểu Bang và Liên Bang.

Kaiser Permanente không phân biệt đối xử trái pháp luật, loại trừ hay đối xử khác biệt với người nào đó vì lý do tuổi tác, chủng tộc, nhận dạng nhóm sắc tộc, màu da, nguồn gốc quốc gia, nền tảng văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng giới tính, tình trạng hôn nhân, tình trạng khuyết tật về thể chất hoặc tinh thần, bệnh trạng, nguồn thanh toán, thông tin di truyền, quyền công dân, ngôn ngữ mẹ đẻ hoặc tình trạng nhập cư.

Kaiser Permanente cung cấp các dịch vụ sau:

- Phương tiện hỗ trợ và dịch vụ miễn phí cho người khuyết tật để giúp họ giao tiếp hiệu quả hơn với chúng tôi, chẳng hạn như:
 - ◆ Thông dịch viên ngôn ngữ ký hiệu đủ trình độ
 - ◆ Thông tin bằng văn bản theo các định dạng khác (chữ nổi braille, bản in khổ chữ lớn, âm thanh, định dạng điện tử để truy cập và các định dạng khác)
- Dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh, chẳng hạn như:
 - ◆ Thông dịch viên đủ trình độ
 - ◆ Thông tin được trình bày bằng các ngôn ngữ khác

Nếu quý vị cần những dịch vụ này, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi theo số **1-800-464-4000 (TTY 711)**, 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ). Nếu quý vị không thể nói hay nghe rõ, vui lòng gọi **711**.

Theo yêu cầu, tài liệu này có thể được cung cấp cho quý vị dưới dạng chữ nổi braille, bản in khổ chữ lớn, băng thu âm hay dạng điện tử. Để lấy một bản sao theo một trong những định dạng thay thế này hay định dạng khác, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi và yêu cầu định dạng mà quý vị cần.

Cách đệ trình phàn nàn với Kaiser Permanente

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử với Kaiser Permanente nếu quý vị tin rằng chúng tôi đã không cung cấp những dịch vụ này hay phân biệt đối xử trái pháp luật theo cách khác. Vui lòng tham khảo Chứng Từ Bảo Hiểm (Evidence of Coverage) hay Chứng Nhận Bảo Hiểm (Certificate of Insurance) của quý vị để biết thêm chi tiết. Quý vị cũng có thể nói chuyện với nhân viên ban Dịch Vụ Hội Viên về những lựa chọn áp dụng cho quý vị. Vui lòng gọi đến ban Dịch Vụ Hội Viên nếu quý vị cần được trợ giúp để đệ trình phàn nàn.

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử bằng các cách sau đây:

- **Qua điện thoại:** Gọi đến ban Dịch Vụ Hội Viên theo số **1-800-464-4000 (TTY 711)** 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ)
- **Qua thư tín:** Gọi chúng tôi theo số **1-800-464-4000 (TTY 711)** và yêu cầu gửi mẫu đơn cho quý vị
- **Trực tiếp:** Hoàn tất mẫu đơn Than Phiền hay Yêu Cầu Thanh Toán/Yêu Cầu Quyền Lợi tại văn phòng dịch vụ hội viên ở một Cơ Sở Thuộc Chương Trình (truy cập danh mục nhà cung cấp của quý vị tại kp.org/facilities để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại kp.org

Quý vị cũng có thể liên hệ trực tiếp với Điều Phối Viên Dân Quyền của Kaiser Permanente theo địa chỉ dưới đây:

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

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California (*Dành Riêng Cho Người Thụ Hưởng Medi-Cal*)

Quý vị cũng có thể đệ trình than phiền về dân quyền với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California bằng văn bản, qua điện thoại hay qua email:

- **Qua điện thoại:** Gọi đến Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế (Department of Health Care Services, DHCS) theo số **916-440-7370** (TTY **711**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Mẫu đơn than phiền hiện có tại: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Trực tuyến:** Gửi email đến CivilRights@dhcs.ca.gov

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ.

Quý vị cũng có quyền đệ trình than phiền về phân biệt đối xử với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ. Quý vị có thể đệ trình than phiền bằng văn bản, qua điện thoại hoặc trực tuyến:

- **Qua điện thoại:** Gọi **1-800-368-1019** (TTY **711** hay **1-800-537-7697**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Mẫu đơn than phiền hiện có tại
<http://www.hhs.gov/ocr/office/file/index.html>

- **Trực tuyến:** Truy cập Cổng Thông Tin Than Phiền của Văn Phòng Dân Quyền tại:
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

NOTICE OF LANGUAGE ASSISTANCE

English: This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000 (TTY 711)** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays. We can also help you with auxiliary aids and alternative formats.

Arabic: تحتوي هذه الوثيقة على معلومات مهمة من Kaiser Permanente. إذا كنت بحاجة للمساعدة في فهم هذه المعلومات، يرجى الاتصال على الرقم **(TTY: 711) 1-800-464-4000** وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية. يمكننا أيضاً تزويدك بمساعدات إضافية وتنسيقات بديلة.

Armenian: Սա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրում ենք զանգահարել **1-800-464-4000 (TTY 711)** հեռախոսահամարով և օժանդակություն ստանալ լեզվի հարցում: Զանգահարեք օրը 24 ժամ, շաբաթը 7 օր՝ բացի տոն օրերից: Մենք նաև կարող ենք օգնել Ձեզ օժանդակ օգնության և այլընտրանքային ձևաչափերի հարցում:

Chinese: 這是來自 Kaiser Permanente 的重要資訊。如果您需要協助瞭解此資訊，請致電 **1-800-757-7585 (TTY 專線 711)** 尋求語言協助。我們每週 7 天，每天 24 小時皆提供協助（節假日休息）。我們還可以幫助您獲取輔助設備和其它格式。

Farsi: این اطلاعات مهمی از سوی Kaiser Permanente می باشد. اگر در فهمیدن این اطلاعات به کمک نیاز دارید، لطفاً با شماره **(TTY 711) 1-800-464-4000** تماس گرفته و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانه روز و 7 روز هفته، شامل روزهای تعطیل موجود است. ما همچنین می توانیم برای شما کمکهای جانبی و به صورتهای دیگر را فراهم کنیم.

Hindi: यह Kaiser Permanente की ओर से महत्वपूर्ण सूचना है। यदि आपको इस सूचना को समझने के लिए मदद की जरूरत है, तो कृपया **1-800-464-4000 (TTY 711)** पर फोन करें और भाषा सहायता के लिए पूछें। सहायता छुट्टियों को छोड़कर, सप्ताह के सातों दिन, दिन के 24 घंटे, उपलब्ध है। हम सहायक साधनों और वैकल्पिक प्रारूपों को प्राप्त करने में भी आपकी मदद कर सकते हैं।

Hmong: Qhov xov xwm no tseem ceeb los ntawm Kaiser Permanente. Yog koj xav tau kev pab kom nkag siab cov xov xwm no, thov hu rau **1-800-464-4000 (TTY 711)** thiab thov kev pab txhais lus. Muaj kev pab 24 teev ib hnuv twg, 7 hnuv ib lim tiam twg, tsis xam cov hnuv caiv. Peb kuj muab tau lwm yam kev pab rau koj thiab ua lwm yam ntaub ntawv.

Japanese: Kaiser Permanente から重要なお知らせがあります。この情報を理解するためにヘルプが必要な場合は、**1-800-464-4000 (TTY 回線 711)** に電話して、言語サービスを依頼してください。このサービスは年中無休（祝祭日を除く）でご利用いただけます。補助器具・サービスや別のフォーマットについてもご相談いただけます。

Khmer: នេះគឺជាព័ត៌មានសំខាន់ មកពី Kaiser Permanente។ បើសិនអ្នកត្រូវការជំនួយ ឲ្យបានយល់ដឹងព័ត៌មាននេះ សូមទូរស័ព្ទទៅលេខ **1-800-464-4000 (TTY 711)** និងស្នើសុំជំនួយខាងភាសា។ ជំនួយគឺមាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ លើកលែងថ្ងៃឈប់សម្រាក។ យើងក៏អាចជួយអ្នកជាមួយនឹងឧបករណ៍ជំនួយទំនាក់ទំនងសម្រាប់អ្នកពិការនិងជាទម្រង់ជំនួសផ្សេងៗ។

Korean: 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, **1-800-464-4000 (TTY 711)** 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외). 또한 보조기구 및 대체 형식의 자료를 지원해 드릴 수 있습니다.

Laotian: ນີ້ແມ່ນຂໍ້ມູນສໍາຄັນຈາກ Kaiser Permanente. ຖ້າວ່າ ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການຊ່ວຍໃຫ້ເຂົ້າໃຈຂໍ້ມູນນີ້, ກະຮຸນາໂທ 1-800-464-4000 (TTY 711) ແລະຂໍເອົາການຊ່ວຍເຫຼືອດ້ານພາສາ. ການຊ່ວຍເຫຼືອມີໃຫ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ບໍ່ລວມວັນພັກຕ່າງໆ. ພວກເຮົາຍັງສາມາດຊ່ວຍທ່ານໃນດ້ານອຸປະກອນຊ່ວຍເສີມ ແລະ ຮູບແບບທາງເລືອກອື່ນໄດ້.

Mien: Naaiv se benx jienv sic dauh waac-fienx yiem naaiv Kaiser Permanente bun daaih. Beiv taux meih qiemx longc mienh tengx doqc naaiv deix waac-fienx liouh porv bun bieqc hnyouv nor, daaix luic douc waac daaih lorx 1-800-464-4000 (TTY 711) aengx caux tov heuc tengx nzie faan waac bun muangx. Mbenc nzoih liouh tengx yiem yietc hnoi benx 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi, simv cuotv hnoi-gec oc. Yie mbuo corc haih mbenc wuotc ginc jaa-dorngx tengx nzie goux aengx caux liouh bun ginv longc sou-guv daan puix horpc meih.

Navajo: Díí éí hane' bíhólníihii át'éego Kaiser Permanente yee nihalne'. Díí hane'ígíí doo hazhó'ó bik'i'í diitííhgóó t'áá shqódí koji' hodíílnih 1-800-464-4000 (TTY 711) áko saad bee áká i'íilyeed yídííkií. Kwe'é áká aná'álwo' t'áá álahjį' naadiindjį' ahéé'ílkidgóó dóó tsosts'id jí áą'át'é. Dahodílingóne' éí dá'deelkaal. Áádóó hane' bee bik'i' di' diitíílgíí dóó t'áá lahgo át'éego hane' nich'í ádoólnííł.

Punjabi: ਇਹ Kaiser Permanente ਵਲੋਂ ਜ਼ਰੂਰੀ ਜਾਣਕਾਰੀ ਹੈ। ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-800-464-4000 (TTY 711) 'ਤੇ ਫੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁੱਛੋ। ਮਦਦ, ਛੁੱਟੀਆਂ ਨੂੰ ਛੱਡ ਕੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਅਤੇ ਦਿਨ ਦੇ 24 ਘੰਟੇ ਮੌਜੂਦ ਹੈ। ਅਸੀਂ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਵਿਕਲਪਿਕ ਟਰਾਂਸਲੇਟਾਂ ਵਿੱਚ ਵੀ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ।

Russian: Это важная информация от Kaiser Permanente. Если Вам требуется помощь, чтобы понять эту информацию, позвоните по номеру 1-800-464-4000 (линия TTY 711) и попросите предоставить Вам услуги переводчика. Помощь доступна 24 часа в сутки, 7 дней в неделю, кроме праздничных дней. Мы также можем помочь вам с вспомогательными средствами и альтернативными форматами.

Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al 1-800-788-0616 (TTY 711) y pida ayuda lingüística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos. También podemos ayudarle con recursos para discapacidades y formatos alternativos.

Tagalog: Ito ay importanteng impormasyon mula sa Kaiser Permanente. Kung kailangan ninyo ng tulong para maunawan ang impormasyong ito, mangyaring tumawag sa 1-800-464-4000 (TTY 711) at humingi ng tulong kaugnay sa lengguwahe. May makukuhang tulong 24 na oras bawat araw, 7 araw bawat linggo, maliban sa mga araw na pista opisyal. Matutulungan din namin kayo sa mga pantulong na gamit o serbisyo at mga alternatibong format.

Thai: นี่เป็นข้อมูลสำคัญจาก Kaiser Permanente หากคุณต้องการความช่วยเหลือในการทำความเข้าใจข้อมูลนี้ โปรด โทร 1-800-464-4000 (โทรมด TTY 711) และขอความช่วยเหลือด้านภาษา เราพร้อมให้ความช่วยเหลือตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ ยกเว้นวันหยุดราชการ เรายังสามารถจัดหาอุปกรณ์และวัสดุช่วยเหลือในรูปแบบอื่นได้อีกด้วย

Ukrainian: У цьому повідомленні міститься важлива інформація від Kaiser Permanente. Якщо надана інформація не зрозуміла й вам потрібна допомога, зателефонуйте за номером 1-800-464-4000 (TTY 711) і попросіть надати вам послугу перекладача. Наші співробітники надають допомогу цілодобово, 7 днів на тиждень, за винятком святкових днів. Також ми можемо допомогти вам, надавши допоміжні засоби й матеріали в альтернативних форматах.

Vietnamese: Đây là thông tin quan trọng từ Kaiser Permanente. Nếu quý vị cần được giúp đỡ để hiểu rõ thông tin này, vui lòng gọi số 1-800-464-4000 (TTY 711) và yêu cầu được cấp dịch vụ về ngôn ngữ. Quý vị sẽ được giúp đỡ 24 giờ trong ngày, 7 ngày trong tuần, trừ ngày lễ. Chúng tôi cũng có thể giúp quý vị với các phương tiện trợ giúp bổ trợ và hình thức thay thế.

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

Important Employee Benefit Program Notices

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

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

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

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

- **Special Enrollment Event:**

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

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

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

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

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

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

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

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

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

PRIVACY NOTICE REMINDER

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

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. You can get another copy of this Notice from 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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.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: 1-800-967-4660

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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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: 711 Email: masspremassistance@accenture.com
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: HSHIPPProgram@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: https://www.hhs.nd.gov/healthcare 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 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 RlTe 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: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services 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://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
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, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

Life Insurance Beneficiary Designation

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

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

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

(Over)

Custodial Designation:

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

Custodian Name: _____ Date of Birth: _____

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.