Southern California Local Union 831 Employer Health Fund

Reference Guide to Your Health Plan

Effective January 1, 2026

Plan Highlights

- The Indemnity/PPO network is managed by Anthem Blue Cross of California's Prudent Buyer Network. For verification of providers, call the Trust Fund Office at 1.877.572.7005 or 626.279.3080.
- Preauthorization required under the Indemnity/PPO network will be made by Anthem Blue Cross of California managed care staff. For assistance, call 1.800.274.7767.
- The primary hourly rate has been increased to $13.40, effective on the work month of September 1, 2024. Your maximum bank has also increased to reflect the rate increase.
- Benefit Charts are available in the center of this reference guide book. The Address Change Form and the Beneficiary card are located at the end of this reference guide book.
- Your Enrollment/Change form is included.
- Learn how to use the Plan's Managed Care Network. Read how you can make a difference to your out-of-pocket expenses. See page 6.
- The Prescription Benefits is managed by Optum Rx.
- Visit our website's Participant Portal for 24/7 access at www.localunion831.trustfunds.com

This booklet contains important information about your Plan. Please review it carefully.

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What You Should Know

The network for the Indemnity/PPO Plan is the Anthem Blue Cross of California Prudent Buyer Network.

It is your responsibility to make sure that your provider is part of the Anthem Blue Cross of California Prudent Buyer Network at the time you receive services. Providers often drop out of the network and fail to notify their patients.

Protect yourself from unnecessary out-of-pocket expenses by always verifying that your provider is still part of the Anthem Blue Cross of California Prudent Buyer Network.

Important Numbers

Anthem Blue Cross of California - Managed Care Department 1.800.274.7767
www.anthem.com

Kaiser Permanente (Multi-Lingual) 1.800.464.4000
www.kp.org (Spanish).....1.800.788.0616

Trust Fund Office Toll Free Number 1.877.572.7005
www.localunion831trustfunds.com

Trust Fund Office 626.279.3080
www.localunion831trustfunds.com

Employee Assistance Program: Claremont EAP 1.800.834.3773
www.claremonteap.com/pages/ca.html and use company name: Local 831

Optum RX 1.800.797.9791
www.optumrx.com

The Trust Fund Office is located at 1055 Park View Drive., Suite 111, Covina, CA 91724

Office hours are from 8 a.m. to 5 p.m., Monday through Friday, except for some holidays.

Customer Service phone hours are from 7 a.m. to 6 p.m., Monday through Friday, except for some holidays.

INTRODUCTION AND PREAMBLE

The Board of Trustees is pleased to provide you with the detailed reference guide to the various health benefits for you and for your eligible dependents (plan participants). It is designed to help plan participants understand the benefit options available and to assist in enrollment or to change their enrollment in the benefit plans offered by the Southern California Local 831-Employer Health Fund (the Plan). This reference guide will also be available at the Trust Fund Office.

The information provided will first serve to guide participants of the Fund through the open enrollment process for benefits. Subsequently, new hires or newly eligible employees will receive this booklet to use for their first enrollment in the benefit plans.

We encourage you to review this reference guide carefully so that you are aware of all the benefits to which you are entitled, as well as some important restrictions and responsibilities. We have prepared this booklet to serve as a detailed reference guide to your various health benefits. However, the information contained does not constitute the Rules and Regulations of the Health Plan which is the legal document governing the Health Plan. The Rules and Regulations are located at the Fund's administrative office (Trust Fund Office). A copy of this document is also available to you upon request. The Trust Fund Office may charge a minimal fee for the cost of photocopying this document and for any postage required.

This reference guide is not a contract and the benefits and coverage provided under the Health Plan to participants are not contractual benefits. Therefore, the benefits and coverage may be reduced, modified or discontinued by action of the Trustees at any time. The Trustees do not promise to continue the benefits and coverage in full or in part in the future, and rights to future benefits and coverage are not vested. In particular, retirement or the completion of the requirements to receive a pension benefit under the Southern California Local 831-Employee Pension Plan does not give any participant or former participant any vested right to continued benefits or coverage under the Health Plan.

The Trustees and the Benefits and Appeals Committee (Benefits Committee) are authorized and empowered to construe the meaning of any doubtful or ambiguous provisions of the Health Plan. Any construction thereof adopted by the Trustees or the Benefits Committee in good faith shall be binding upon the Fund and all beneficiaries. The Trustees and the Benefits Committee are authorized and empowered to generally do all things, execute all such agreements, adopt and promulgate all such reasonable rules and regulations, take all such proceedings and exercise all such rights and privileges as are necessary in the establishment, maintenance and administration of the Health Plan.

The nature and extend of benefits provided by the Health Plan and rules governing eligibility are determined solely and exclusively by the Trustees of the Plan. Employees of the Trust Fund Office have no authority to alter those benefits and eligibility rules. Any interpretations of opinions given by employees of the Trust Fund Office are not binding upon the Trustees and cannot change the benefits and the eligibility rules.

If you have any questions about the Plan, please call the Trust Fund Office at 1.877.572.7005 or 626.279.3080 or write to the Trust Fund Office at 1055 Park View Drive., Suite 111, Covina, CA 91724.

ENROLLMENT

BACKGROUND

The benefits provided under this Fund are made possible by monies received by the Southern California Local 831-Employer Health Fund primarily as a result of the collective bargaining agreements negotiated between Employers and Tradeshow and Sign Crafts Local Union 831. Collective Bargaining Agreements are available at the Local 831 office.

The Board of Trustees is comprised of six trustees. Three of the trustees are appointed by the employers and three trustees are appointed by the Union. The Trustees as a board represent the employee-beneficiaries.

Monies received by the Fund and the benefits provided by the Plan are maintained and administered under the direction of the Board of Trustees. The trustees serve without pay as a service to the industry, the employees and other beneficiaries participating in the Plan.

EFFECTIVE DATE OF COVERAGE

For new hires, your effective date of coverage is determined when you have met all eligibility requirements. (See Eligibility Requirements)

Changes in coverage involving the addition of dependents are effective retroactive to the date of the event, such as marriage, birth or adoption, providing the application is filed within 30 days of the event.

Addition of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the Trust Fund Office. Effective June 1, 2010 children up to twenty-six (26) years of age may be eligible for continued coverage if they are not eligible for health coverage from an employer (other than a parent's employer).

A COBRA notice will be mailed to your dependents to offer continued coverage that are identical to your previous coverage. The cost of COBRA coverage for your dependents will be included with the COBRA notice received.

EMPLOYEE-BENEFICIARY RESPONSIBILITIES

Employee-beneficiaries are responsible for:

- Providing current and accurate personal information as described in this booklet.
- Verifying that a provider is contracted with the Anthem Blue Cross of California PPO network.
- Making appropriate self-payments timely to maintain coverage when necessary.
- Complying with the Fund's rules.

CHANGE OF COVERAGE

To change your coverage, (Medical Plan) you should contact the Trust Fund Office and complete an enrollment change form. You may change your medical plan once every rolling twelve (12) month period from the date of your last change, provided you have participated in the same medical plan for at least twelve (12) months and under the following circumstances:

- You marry and want to enroll your spouse and your newly eligible dependent children.
- You need to enroll a newborn or newly adopted child.
- You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death).
- Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
- You move out of your plan's service area.
- You are only allowed to increase your plan level of coverage one time during the 12 month period after your plan level selection.

ELIGIBILITY

BACKGROUND

The Southern Californian Local Union 831 Employer Health Fund Plan provides a health care package to all eligible participants and their eligible dependents. In order to qualify for these benefits, participants and dependents must meet the eligibility requirements of the Health Plan. The following sections describe the basic eligibility requirements for health Plan coverage, how eligibility is maintained and the programs available if eligibility is lost.

If you and your dependents are eligible for coverage, the Trust Fund Office must receive the Enrollment Form (completed), along with any supporting documents for your dependents.

Original Certificate of Marriage of your spouse and original Certificate of Birth of each dependent will be required to establish eligibility. Photocopies will not be accepted.

The Health Plan does not cover charges for conditions after eligibility terminates, even if those conditions developed during a period of Health Plan eligibility or if treatment for those conditions began during a period of Health Plan eligibility.

The benefits under the Health Plan are not vested or guaranteed. They may be modified, reduced or canceled at any time by the Board of Trustees.

ELIGIBILITY REQUIREMENTS

Hours and benefit credits you earn, as well as the amount your employer contributes on your behalf would determine the level of benefits you and/or your dependents would receive.

(If there is a difference between the hours you have worked and the contribution your employer has made towards your benefits, you may have to submit your check stubs to the Trust Fund Office.)

The monthly hours required to be eligible for Health Plan benefits under all Plan Levels are outlined on the following page.

For monthly hours required at other contribution rates, contact the Trust Fund Office at 1.877.572.7005 or 626.279.3080.

BENEFIT CREDIT/HOUR BANK

You may accumulate up to a maximum of five (5) months of benefit credits/hours in your benefit credit/ hour bank (Hour Bank).

If you work more hours than are necessary to earn the benefit credit/hours required for the level of coverage you have selected, you may bank a reserve of benefit credits/hours. These benefit credits/hours will be used towards the monthly contributions needed to provide you and your dependents with health benefits until there is not enough credits and hours remaining in your hour bank.

METHODS OF OBTAINING ELIGIBILITY

There are two ways employers may make contributions on your behalf into the Plan:

Your employer may contribute on a ***per hour basis***. In this case, you will need to preselect your level of coverage. All hours contributed for you are used to calculate your Benefit Credits. If you have sufficient credits, those credits are used to provide for your monthly coverage (**See Monthly Schedule of Chart on the following page to determine which level of coverage you would be able to select**).

Credits earned above the monthly required amount needed for the level of coverage you preselected are banked as a reserved benefit credit.

An employer may contribute ***a fixed amount per month (flat rate)***. If your employer contributes a fixed amount per month on your behalf, you will be assigned to the level that is appropriate for that contribution.

The Trust Fund Office is located at 1055 Park View Drive., Suite 111, Covina, CA 91724.

Office hours are from 8 a.m. to 5 p.m., Monday through Friday, except for some holidays.

Customer Service phone hours are from 7 a.m. to 6 p.m., Monday through Friday, except for some holidays.

Monthly Hourly Schedule Chart				
	Level 1	Level 2	Level 3	Level 4
Benefit Credits/Hours Needed	140	120	100	80
Hours needed X hourly contribution (primary rate of $13.40)*	$1,876.00	$1,608.00	$1,340.00	$1,072.00
Maximum hour bank you could earn	$9,380.00	$8,040.00	$6,700.00	$5,360.00

* At the contribution rate of $13.40, which became effective for most participants on March 1, 2024. After September 1, 2026, please call the Trust Fund Office for a current rate.

Steps to Become Eligible

Date Employee Becomes Eligible for Coverage

If you are a new employee or if you previously lost eligibility, you become eligible for Employee coverage on the first day of the fifth month of a period that begins with three continuous months during which you average the minimum hours for the coverage level that you have selected as long a you are credited with at least 25 hours in the first month.

- Select the level you want and are qualified for. (Multiply the hours you estimate you will work by your employer's contribution rate to determine the level you can reasonably expect to maintain throughout the calendar year.)
- Select the level coverage you want (Kaiser plan or Indemnity plan).
- Complete and sign the Enrollment/Change Form
- Submit the Enrollment/Change Form to the Trust Fund Office.

Under the twelve (12) month rolling enrollment, once you have chosen your medical plan, you may change your medical plan once every rolling twelve (12) month period from the date of your last change, provided you have participated in the same medical plan for at least twelve (12) months.

HOW TO USE THE PLAN'S MANAGED CARE NETWORK

The Health Plan uses managed care providers to help control the costs of your health care coverage. **When you use the managed care programs, both you and the Plan will save money** because the network providers have agreed to accept a designated fee schedule for their services. Any amount over the contracted amount of your medical, vision, mental health, chemical dependency, prescription drug, chiropractic, physical therapy and acupuncture benefits may not be your responsibility. **If you use a non-contracted provider, any amount over the Plan's allowance will be your responsibility and that is an unnecessary out-of-pocket expense to you**.

For each new calendar year, the remaining charges are paid to the provider or reimbursed to you at a percentage after the annual deductible has been paid. The difference between eligible charges and the percentage you pay is called a copayment. The copayment would be your responsibility. ***Please read the respective Summary of Benefits Charts*** that apply to your coverage. Many of the benefits do limit the number of visits allowed in a calendar year. **Even if you do visit a contracted provider, visits over the limited number would be your responsibility**.

LOCATING A NETWORK PROVIDER

You may obtain a list of providers in your area by calling the Trust Fund Office at 1.877.572.7005 or 626.279.3080. If you have access to internet service, you may go on line at www.anthem.com to obtain a list of providers. If you use dental and/or vision providers contracted through Anthem Blue Cross, your benefit will be maximized and your out-of-pocket expenses will be lower.

TYPE OF MANAGED CARE PLANS

The Health Plan has two different kinds of health care plans – the Indemnity/PPO plan and the Health Maintenance Organization (HMO) plan.

The Plan's Indemnity/PPO network is managed through Anthem Blue Cross of California and the Plan's HMO is Kaiser Permanente.

Both plans place restrictions on access to medical services, some more than others, to lower costs to the Plan. Participants of these plans must meet all of the requirements before they are treated by a provider. Some of the requirements would include the prior approval for hospitalization and certain outpatient procedures.

Kaiser Permanente

Kaiser is a health care plan that will organize, control, pay for and provide almost every aspect of health care that a member may need.

Members of Kaiser are cared for mainly through organized networks of preselected doctors, hospitals and other health care providers.

Kaiser will let you see the doctors and use the hospitals in its network and service areas when it pays for your care. If you are treated outside of the HMO's network, the cost of your care usually won't be paid for unless the care was authorized ahead of time by your Kaiser physician or it was for any emergency.

Indemnity/PPO Plan

The Indemnity/PPO plan will allow you more choices than Kaiser. The services from doctors or hospitals are offered at lower costs to those who use the Anthem Blue Cross of California network providers.

If you have selected the Indemnity/PPO Plan, you are encouraged to use physicians, hospitals and other health care providers that have been contracted with Anthem Blue Cross of California and are part of their network to help keep your out-of-pocket costs down and to help keep the Plan's costs down.

OVERVIEW OF THE INDEMNITY/PPO PLAN AND THE KAISER/HMO PLAN

Indemnity/PPO Plan

The medical Indemnity Plan is offered through the Employer Health Fund. Participants in this Plan normally receive the highest monetary benefit when staying with doctors, specialists and hospitals that are contracted through Anthem Blue Cross and are within the Preferred Provider Organization (PPO) network.

The important things to remember about the Indemnity Plan are:

- You receive the highest monetary benefit when staying within the Anthem Blue Cross PPO network.
- A maximum deductible (individual/family) amount must be paid by the patient before covered medical benefits are reimbursed or paid.
- You will be required to pay a copayment (percentage) for covered medical services.
- Certain treatments must be preauthorized by Anthem Blue Cross Managed Care before services are provided.
- You should always verify that your doctor or any specialist you are referred to is part of the PPO network before utilizing covered services. Providers may be added or deleted throughout the Plan year.

Always call the day of or the day before you receive services because non-contracted providers may charge you more than the allowable amount. And the charges over the allowable amount would be your out-of-pocket expense.

Any out-of-pocket expenses above the allowable contracted amount for covered services become the participant's responsibility. (See the following page for Kaiser Permanente/HMO.)

Medical – Kaiser Permanente / HMO Plan

The HMO Plan is offered through Kaiser Permanente (Kaiser). Plan members are required to obtain their health care services from doctors and hospitals affiliated with Kaiser. It is common practice for the plan member to choose a primary care physician who will treat and direct health care decisions and who will coordinate referrals to specialists within the Kaiser network. All members require a Kaiser Member card with an assigned number (medical record number) to receive services from a facility.

If you are properly enrolled and have not received a Kaiser card or a medical record number, you may call the Kaiser's customer service at 1.800.464.4000 and request a medical record number.

If you or your dependents may require frequent medical attention, please call the Kaiser Permanente Customer Service at 1.800.464.4000 for a facility near you because there may be restricted geographic regions and this may limit the coverage area. The services described in Kaiser's Disclosure Forms are covered only if all of the following conditions are satisfied:

- The services are medically necessary.
- The services are provided, prescribed, authorized or directed by a provider or a Kaiser physician.
- You receive the services from Plan providers inside Kaiser's service areas, except where specifically noted to the contrary for authorized referrals, Kaiser's visiting member program, emergency care, out-of-area urgent care and post-stabilization care described in the Evidence of Coverage.

Note: Members of Kaiser Permanente should refer to ***Your Guidebook*** for the types of covered services that are available from each Plan Facility (facility) because at some facilities only specific types of covered services are provided.

IMPORTANT NOTICES

Many federal and state laws guide the administration of all health benefit plans. While the plan actually governs your rights and benefits under each plan in which you are enrolled, the following information is provided to help you understand your statutory rights and benefits. If any discrepancy exists between the information provided in this section and the Plan, the Plan will prevail.

If you have any questions about this section, please call the Trust Fund Office at 1.877.572.7005 or 626.279.3080.

Grandfathered Status Notice

The Southern California Local Union 831 – Employer Health Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, agrandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to otherplans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grand fathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1055 Park View Drive., Suite 111, Covina, CA 91724; 1.877.572.7005. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1.866.444.3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Women's Health and Cancer Rights Act (WHCRA)

Your health plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services, including the following services:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Your plan will provide coverage in consultation with the attending physician and patient.

Coverage for breast reconstruction and related services will be subject to deductible, copayments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan. If you have any questions about the Women's Health and Cancer Rights Act, please call the Trust Fund Office at 1.877.572.7005 or 626.279.3080.

COBRA Continuation Coverage

COBRA continuation coverage provides for a temporary extension of coverage under this Plan. See the Summary Plan Description for an explanation of COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it, along with information on other coverage options that may cost less than COBRA continuation coverage.

HIPAA

The Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule requires the Employer Health Fund to give you a notice that provides a clear, user friendly explanation of your rights with respect to your personal health information and the Health Fund's privacy practices. You can find this notice in the Summary Plan Description.

COBRA Monthly Premiums - Effective Eligibility Month of January 2023			
Level 1	Level 2	Level 3	Level 4
$1,876.00	$1,608.00	$1,340.00	$1,072.00

COBRA rate effective Eligibility month of January 2026.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits or any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a normal vaginal delivery or
- 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider (physician), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

If any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the Plan may still require precertification or preauthorization from the Plan or the issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

The Mental Health Parity and Addiction Equity Act of 1996

The Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law on September 26, 1996. MHPAEA provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on 31 medical / surgical benefits. MHPAEA's provisions are subject to concurrent jurisdiction by the Department of Labor, the Treasury and the Health and Human Services.

The Department of Labor, the Treasury, and Health and Human Services issued interim regulations that interpret MHPAEA. The regulations clarify the statutory requirements and provide information valuable to employers and employees in understanding their obligations and rights under the law.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care, use an out-of-network air ambulance provider, or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. *If you believe you've been wrongly billed,* you may contact the federal government's No Surprises Help Desk at 1 (800) 985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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 July 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://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
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/?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/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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 July 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 Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

Help Identify Fraudulent or Abusive claims

Protect your Trust Fund by identifying and reporting fraudulent or abusive claims!

What to look out for:

- Billing for services that were never provided.
- Billing for medically unnecessary services.
- Duplicate submission of claims for the same service or supply.
- Misrepresenting the service provided through:
    - Changing the service to a more expensive type of service.
    - Reporting the wrong diagnosis or service.
- Misrepresenting the dates, location or provider of the service.
- Soliciting, offering, or receiving a kick-back.
- Waiving or reducing deductibles/copayments.
- Intentionally omitting other coverage or supporting false injury claims for higher reimbursement levels.
- Shaping the diagnosis, treatment, and/or billing coding to fit plan reimbursement provisions, for example:
    - Plastic surgery “nose job’ billed as a deviated septum.
    - Altering the diagnosis code order for greater benefit.
    - Ordering tests inconsistent with diagnosis indicated.
    - Extensive testing for multiple family members.

If you identify any possible fraud or abuse in the claims submitted for services rendered for you or your eligible dependents, please notify the Trust Fund Office immediately.

If you have any questions, please call the Trust Fund Office at (877) 572-7005 or (626) 279-3080 and / or visit our website at www.localunion831trustfunds.com.

Important Notice
About Your Privacy Practices For Protected Health Information
Southern California Local 831 – Employer Health

We are required by law to remind you of the availability of the Fund's Notice of Privacy Practices issued in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the Notice of Privacy Practices was provided to you previously. Requests for copies of the Notice of Privacy Practices may be made to the Fund's Privacy Officer in writing, by email or by telephone at the address and telephone number listed below:

Contact information
Via e-mail: privacyofficer@pswadmin.com
Customer Service #: (626) 279-3080
Website: www.localunion831trustfunds.com

We will send a hard copy of the Notice to you by mail or, upon request, we can send you the notice electronically via e-mail.

LOCAL 831 EMPLOYER TRUST FUNDS HEALTH BENEFICIARY CARD

Employee's Last Name | First Name | M.I. | SS Number | Date of Birth

Street Address | City | State | Zip Code

The Plan has established "default" beneficiaries for the Health & Welfare Death Benefit. This is what most people will choose and will be applied to your benefits upon your death. If you wish to use the DEFAULT beneficiaries, please mark the box in Section A and complete items 1 through 6 and item 8 below. If you wish for a different set of beneficiaries or different order of beneficiaries, please mark the box in Section B and complete items 7 and 8 below.

Section A

☐ I choose the DEFAULT beneficiaries and have filled in items 2 and 3 below as required. (If you fail to select either choice, the Default will be applied).

1. My spouse at the time of my death. [Absent a waiver signed by your spouse this will be the automatic form of benefit for your pension]. If I leave no spouse, then
2. To the following persons:

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

3. If any of those named in item 2 above should die before me, that person's share

☐ **A.** shall be divided among the remaining named persons in proportion to their percentages; **or**

☐ **B.** go to the following person or persons:

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

4. ☐ If none of the persons survive me, then in accordance with the terms of my living trust.
5. ☐ If I leave no living trust, then in the same manner as set out in the residuary provisions of my will.
6. ☐ If I leave no will, then according to the laws of intestacy in the state of my residence at the time of my death.

Section B

7. ☐ I do not want the DEFAULT beneficiaries and instead I designate the following:
   My spouse at the time of my death. [Absent a waiver signed by your spouse this will be the automatic form of benefit for your pension].
   If I leave no spouse or there is a signed waiver, then:

Name of Primary Beneficiary | Primary Beneficiary SS Number

Address of Primary Beneficiary | Relationship of Primary Beneficiary

Name of Secondary Beneficiary | Secondary Beneficiary SS Number

Address of Secondary Beneficiary | Relationship of Secondary Beneficiary

8. I am currently ☐ married or ☐ not married. If married, my spouse information is as follows:

Spouse's Name | Spouse's Cell Phone number

Spouse's Address | Spouse's Social Security number

Signature:_____ Date: _____
Participant

LOCAL 831 EMPLOYER TRUST FUNDS PENSION BENEFICIARY CARD

Employee's Last Name | First Name | M.I. | SS Number | Date of Birth

Street Address | City | State | Zip Code

The Plan has established "default" beneficiaries for the Pension Death Benefit. This is what most people will choose and will be applied to your benefits upon your death. If you wish to use the DEFAULT beneficiaries, please mark the box in Section A and complete items 1 through 6 and item 8 below. If you wish for a different set of beneficiaries or different order of beneficiaries, please mark the box in Section B and complete items 7 and 8 below.

Section A

☐ I choose the DEFAULT beneficiaries and have filled in items 2 and 3 below as required. (If you fail to select either choice, the Default will be applied).

1. My spouse at the time of my death. [Absent a waiver signed by your spouse this will be the automatic form of benefit for your pension]. If I leave no spouse, then
2. To the following persons:

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

3. If any of those named in item 2 above should die before me, that person's share
   - ☐ **A.** shall be divided among the remaining named persons in proportion to their percentages; **or**
   - ☐ **B.** go to the following person or persons:

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

Name/Relationship | SS Number | Address | Cell Phone No. | Percentage

4. ☐ If none of the persons survive me, then in accordance with the terms of my living trust.
5. ☐ If I leave no living trust, then in the same manner as set out in the residuary provisions of my will.
6. ☐ If I leave no will, then according to the laws of intestacy in the state of my residence at the time of my death.

Section B

7. ☐ I do not want the DEFAULT beneficiaries and instead I designate the following:
   My spouse at the time of my death. [Absent a waiver signed by your spouse this will be the automatic form of benefit for your pension].
   If I leave no spouse or there is a signed waiver, then:

Name of Primary Beneficiary | Primary Beneficiary SS Number

Address of Primary Beneficiary | Relationship of Primary Beneficiary

Name of Secondary Beneficiary | Secondary Beneficiary SS Number

Address of Secondary Beneficiary | Relationship of Secondary Beneficiary

8. I am currently ☐ married or ☐ not married. If married, my spouse information is as follows:

Spouse's Name | Spouse's Cell Phone number

Spouse's Address | Spouse's Social Security number

Signature: _____ Date: _____
Participant

Beneficiary Selection or Change

Please complete the above form if you have not already selected a beneficiary or you wish to change your beneficiary for your life insurance benefits that are provided to you through the Health Plan. You should also designate a beneficiary for any benefits that may be available through the Pension Plan. If you designate someone other than your spouse, please be aware that California is a community property state and your spouse must consent to someone else designated as your beneficiary.

Member notes

LOCAL UNION 831 EMPLOYER TRUST FUNDS
CHANGE OF ADDRESS NOTIFICATION CARD

Social Security Number

Employee's last name	First name	M.I.	Date of birth Month Day Year

Employee's old address

Employee's New Street Address (Provide Street, Apt. No., City, State, Zip Code)

Employee's New Mailing Address if different from line above

Contact Telephone Number (Include Area Code)
● Daytime No. _____

Preferred Language
● English ● Spanish

Signature Date



LOCAL UNION 831 EMPLOYER TRUST FUNDS
CHANGE OF ADDRESS NOTIFICATION CARD

Social Security Number

Employee's last name	First name	M.I.	Date of birth Month Day Year

Employee's old address

Employee's New Street Address (Provide Street, Apt. No., City, State, Zip Code)

Employee's New Mailing Address if different from line above

Contact Telephone Number (Include Area Code)
● Daytime No. _____

Preferred Language
● English ● Spanish

Signature Date