Welcome

to the

Sheet Metal Workers' Health Plan

of Southern California, Arizona & Nevada

Plan A-NV

Aviso a los participantes que hablan espanol: Si tiene alguna pregunta tocante este aviso, o requiere alguna otra informacion tocante a su cobertura de salud, por favor no dude en comunicarse con la Oficina Administrativa al 800-947-4338, donde habra varios representantes bilingiies que con gusto le ayudaran.

Your eligibility for benefits under Plan A is established and continued on a month-to-month basis, and is determined by the number of hours you work each month. Please refer to pages 9 through 32 of the enclosed Summary Plan Description for details.

Choosing the right medical plan is a very important decision. Once you have elected a medical plan, you may change your election ***only*** during the next Annual Open Enrollment. **Exceptions are made only if you are enrolled in an HMO or EPO and you move outside their service area**, so please review this information and choose your medical plan carefully.

The following is a description of the contents of this packet. **To ensure the best coverage available for you and your eligible dependents, please read all of this information very carefully. Then, complete and return the 2 forms indicated with a "✓" to the Administrative Office as soon as possible**. If you have any questions, or are missing any of the listed items, please do not hesitate to contact the Eligibility Department. We are here to assist you!

-- General Information --

Summary Plan Description- (*red booklet*) Please keep this book handy for future reference, as it explains the rules of the Plan, as well as the requirements for maintaining eligibility for Sheet Metal Workers and their eligible dependents under Plan A. The Fee-for-Service medical benefits are also detailed, beginning on page 33.

✓ **Participant Data Form**- (*white form w/ green print*) **Complete and return this form to the Administrative Office with documentation for all dependents** (i.e. marriage certificates, birth certificates). Eligibility for benefits **will not** be verified on dependents without the proper documentation. Please note that **you must also notify the Administrative Office immediately when dependent status changes**. If you do not do so, you may be held responsible for any claims and/or premiums paid on behalf of any ineligible dependents. Please refer to pages 18-21 of the Summary Plan Description for more details regarding eligible dependents.

✓ **New Eligible Reply Form** - (*grey form*) **Complete and return this form to the Administrative Office within 10 days of receipt of this packet**. Returning this form **does not** enroll you in an HMO medical plan. If you have requested HMO materials, we will mail you the enrollment packets for the Plan(s) indicated. If, after reviewing the materials, you decide to enroll in an HMO, **you must return a completed HMO enrollment form** to the Administrative Office within 60 days of your initial eligibility date. You will then receive written confirmation of your HMO effective date.

--Your Medical Benefits –

For the first month of coverage, all eligible participants are automatically covered under the Fee-For-Service PPO medical plan. You have 60 days from your initial eligibility date to elect an HMO, if you so choose. If you enroll in an HMO, the Fee-for-Service PPO medical plan will be continued until your HMO effective date. **After 60 days, you will not have the option to switch medical plans until the next Annual Open Enrollment.**

Summary Comparison of Medical Plan Options - (*grey fold-out chart*) shows a brief side-by-side comparison of the medical plans available in the state of Nevada under Plan A. For questions on specific benefits, please call the Customer Service numbers indicated.

Depending on your zip code, you may have a choice of the following 4 medical plan options:

- the Fee-for-Service (Indemnity) self-funded PPO medical plan provided by the Trust,
- an HMO plan provided by Health Plan of Nevada (HPN),
- an HMO plan provided by Hometown Health Plan (Northern Nevada only),
- an EPO plan provided by United HealthCare.

About HMOs/EPOs: When you enroll in an HMO (Health Maintenance Organization) or EPO (Exclusive Provider Organization) medical plan, you must use that HMO or EPO's medical providers and hospitals for all of your medical care. No benefits are provided if you use non-contracted, except for certain medical emergencies. Each medical plan also has its own prescription drug program, which must be used.

To receive and review detailed information and a complete enrollment packet(s) on the HMO/EPO medical plans, please check the appropriate boxes on the "New Eligible Reply Form". Your benefits under the health plan of your choice will become effective on the first day of the month following receipt of your HMO or EPO enrollment form, provided your enrollment form is received within 60 days of your initial eligibility date AND prior to the 15th of the month. If your HMO/EPO enrollment form is received within 60 days of your initial eligibility date and after the 15th of the month, there will be an additional full month before your HMO effective date.

The Fee-for-Service PPO Medical Plan is a comprehensive major medical plan which offers the flexibility of seeing doctors outside of a "managed care" environment. Detailed benefit information is located in the Summary Plan Description, beginning on page 33. **All eligible participants are automatically enrolled on the Fee-for-Service PPO Plan for the first month of coverage.** To locate participating PPO doctors and facilities, please visit our website at SMBPAC.org and click on the **Blue Cross Nevada** icon.

You will automatically receive a medical ID card directly from the Anthem Blue Cross PPO plan. This card will no longer be valid if you enroll in an HMO/EPO medical plan.

--Your Prescription Benefits--

Are determined by your medical plan. While enrolled on the Fee-for-Service PPO medical plan, you must use the Express Scripts pharmacy network for all routine and maintenance (mail-order) prescriptions. **You will automatically receive a prescription ID card directly from ExpressScripts. If you enroll in an HMO or EPO plan, you must then use that HMO/EPO for all your prescription needs, and your ExpressScripts card will no longer be valid.**

--Your Dental Benefits--

Summary Comparison of Dental Plan Options - *(yellow folded chart)* This summarizes the benefits available to you under the two Dental Plans as detailed below.

***DeltaCare USA Dental Plan (DMO)*:** You will automatically be enrolled in the DeltaCare USA DMO plan. Under the DeltaCare dental plan if you do not select a dentist in the network, you will be assigned to a dentist according to your residence zip code. If you go to a dentist other than the network dentist you have selected, you and/or your dependents **will not** have any dental coverage for those services rendered, except for certain dental emergencies. After your initial selection, you may change your dental office by calling DeltaCare USA Customer Service at (800) 422-4234, or by visiting their website deltadentalins.org. There are no claim forms to fill out and the Fund pays DeltaCare USA directly for your dental care needs. Covered services and supplies are provided for specified co-payments.

If you do not reside within 30 miles of a DeltaCare USA network dentist, please contact the Administrative Office immediately.

Delta Preferred Option Dental Plan (DPO)**:** Under the Delta Preferred Option dental plan, you may use *any* dentist you wish, but it is to your advantage to select a DPO dentist, as his or her fees will have been accepted in advance by Delta. Claims forms must be submitted to Delta Dental plan for payment. You may find a dentist in the DPO network by visiting the Delta Dental website deltadentalins.org . The following Delta Preferred Option Dental plan information is enclosed: 1) Highlights of Benefits available, 2) Evidence of Coverage.

If you wish to enroll in the Delta Preferred Option Dental Plan, you must complete and return the Delta Preferred Option Dental Plan Enrollment Form to the Administrative Office. Enrollment forms received by the 15th of the month will be processed for an effective date of the first day of the next month.

--Your Vision Benefits--

Blue View Vision - Regardless of which medical plan you choose, your Vision benefits are a separate benefit available under Anthem's Blue View Vision plan. The enclosed flyer explains the benefits that are available. You will automatically receive a vision ID card directly from Anthem Blue View Vision. To utilize your benefits, simply make an appointment with a participating Blue View Vision provider. Your provider will then contact Anthem to verify your eligibility. If you need help in locating a Blue View Vision provider, call (866) 723-0515, or visit their website at anthem.com.

--Your Employee Assistance Benefits—

Beat It! Program - Regardless of which medical plan you choose, you will still have benefits available under the Beat It! Program. If you are enrolled in an HMO or EPO, you may choose between the HMO/EPO substance abuse benefits, or use them in combination with the Beat It! Program. This pamphlet explains the benefits available under the Beat It! program.

--IMPORTANT--

The following IMPORTANT information is outlined in the enclosed Summary Plan Description (red booklet).
To avoid a lapse or loss of coverage, please review this information carefully !

► There is a **full month between actual hours worked and benefit month**. Therefore, hours worked in the month of January will be applied to coverage for the month of March, hours worked in February will be applied to coverage for the month of April, and so forth. After you have initially established eligibility, 120 hours per month is deducted from your Hour Bank for each month of coverage.

► It is **YOUR responsibility to know how many hours are in your Hour Bank, and when your coverage will terminate**. The Administrative Office will send reminder notices when your hour bank falls below 360 hours, and again when it falls below 240 hours. This will allow you the opportunity to avoid a lapse of coverage by enrolling in the Unemployed / Disabled Self-pay Program at a reduced monthly premium. If, after receiving your 240 hour notice you return to work and continue to work 120 hours or less per month, you will not bank hours, and **will not receive another reminder notice until your Hour Bank is built above the 240 hour threshold.**

► If you are unable to perform your normal Sheet Metal duties **due to an injury or illness**, you **may be eligible for an extension of benefits, of up to 3 months of coverage**. You must contact the Administrative Office and complete the necessary form within 30 days of the date of your injury.

► Moving? **Please be sure to notify the Administrative Office, in writing, immediately**. This will assure that you do not experience a lapse in coverage, and continue to receive all necessary and important information regarding your health coverage.

☛ **REMINDER**: **Please complete and return the enclosed *Participant Data Form* and New Eligible Reply Form within IO days. Remember, returning the Reply Form does not enroll you in a medical HMO/EPO plan. You must submit a completed Enrollment Form for the HMO/EPO Plan of your choice.**

The Administrative Office confirms, in writing, all HMO/EPO medical plan enrollments, all eligible dependent enrollments, and plan effective dates. **If you do not receive a written confirmation after you have submitted a completed HMO enrollment form, or documents to enroll eligible dependents, please contact the Administrative Office.**

If you have any questions, please do not hesitate to contact this office!

Sheet Metal Workers' Trust Funds
of Southern California, Arizona, & Nevada
P.O. Box 10067
Manhattan Beach, CA 90266
phone (800) 947-4338 or (310) 798-6572
fax (310) 798-0766

Sheet Metal Workers' Health Plan
of Southern California, Arizona & Nevada

January 2027

Summary Comparison

Of

Medical Plan Options

Plan A

Includes HMO Plan Options Available in

Nevada

To ensure the best coverage is available for you and your eligible dependents, please review this comparison very carefully. **Once you have elected a medical plan, you may change your election only during the next Annual Open Enrollment.** Exceptions are made only if you move outside of your selected plan's service area, so please ***choose carefully***.

All completed enrollment forms received by the 15th of the month are processed for an effective date of the 1st day of following month.

Aviso a los participantes que hablan español: Si tiene alguna pregunta por favor no dude en comunicarse con la Oficina Administrativa al 800-947-4338, donde habrá varios representantes bilingües que con gusto le ayudarán.

Important: This **is <u>not</u> a contract. This is a *summary* of the medical plan options available to you. The group agreements and Plan documents must be consulted to determine the exact terms and conditions of coverage. All benefits are subject to change.**

The Fee**-for-Service Plan** - is a comprehensive major medical plan which offers you the flexibility of "choice". Under this Plan, you may use any doctor or go to any facility you choose, within the United States. If you utilize a provider participating in the Plan's PPO network, however, your out-of-pocket expenses are greatly reduced. **To avoid additional unexpected out-of-pocket expenses, pre-authorization is highly recommended prior to receiving certain services, as indicated by an asterisk (*). For pre-authorization, please call Anthem Blue Cross at 800-832-7850.**

The **HMO and EPO Plans** (*Health Maintenance Organization / Exclusive Provider Organization)* - provide quality care under a **managed care** environment, within a **defined service area.** When you enroll in an HMO or EPO plan, you <u>must</u> use their medical providers and hospitals for all of your medical care, including prescription drugs. **No benefits are provided if you, or *your eligible dependents*, use non-contracted providers**, except for certain medical emergencies. There are no claim forms to fill out, and the Fund pays the HMO/EPO directly for your health care needs. Most routine health care services are provided to you for specified co-payment amounts at the time of service, but deductibles and co-insurances apply to others.

Each HMO/EPO has a limited service **area**, which is defined in each enrollment packet. To enroll in an HMO or EPO, you must reside in and have all medical services performed within their defined service area. **<u>If you enroll in an HMO or EPO and have an eligible dependent(s) residing in a separate household which is *outside* of your selected Plan's service area *(i.e. college students, adult children, or children residing with ex-spouses)*, there may be no benefits available for that dependent</u>**. In addition, if you travel out of town to work, or plan to do so, **you may have <u>no</u> benefits available** while you are outside of your selected plan's service area.

Active Plan A – Nevada 2027	**Fee-for-Service (Anthem Blue Cross)** ***Self-funded Plan***		**United Healthcare** ***Choice EPO Plan***	**Health Plan of Nevada** ***Solutions Value HMO***	**Kaiser Permanente Nevada (Formerly Hometown Health)** ***HMO Plan***
Plan Feature	**All benefits are payable based on the allowable charges, as defined in the Summary Plan Description.** **Pre-authorization is recommended for all benefits indicated with an asterisk (*).**				Available in **Northern Nevada** <u>only</u>
	PPO Provider	**Non-PPO Provider**			
Annual Deductible	$300 per person; maximum of 3 deductibles per family **Deductible applies to most services**	$600 per person; maximum of 3 deductibles per family **Deductible applies to most services**	$500 per person; $1,000 per family maximum **Deductible applies unless otherwise noted**	$500 per person; $1,000 per family maximum **Deductible applies unless otherwise noted**	$500 per person; $1,000 per family maximum **Deductible applies unless otherwise noted**
Annual Out-of-Pocket Limit	Plan pays 100% of allowable charges after you have incurred a total of $3,400 out-of-pocket per year *($6,800 for a family)*	None Benefits do not increase from 50%	Plan pays 100% after eligible out-of-pocket costs reach $3,000 in a year *($6,000 for a family)*	Plan pays 100% after eligible out-of-pocket costs reach $2,000 in a year *($6,000 for a family)*	Plan pays 100% after eligible out-of-pocket costs reach $3,000 in a year *($6,000 per family)*
In Patient Hospital	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Out Patient Hospital	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	You pay $350 per procedure after deductible	You pay $200 per procedure after deductible
Extended Care Facility *(Skilled Nursing)*	Plan pays 75% of allowable charges after deductible; 60 days maximum per calendar year	Plan pays 50% of allowable charges; 60 days maximum per calendar year	Plan pays 80% after deductible; 100 days maximum per calendar year	You pay $300 per admission after deductible, waived if admitted from an acute care facility; 100 days maximum per calendar year	Plan pays 80% after deductible; 100 days maximum per calendar year
Office Visits			***Not Subject to Deductible***	***Not Subject to Deductible***	***Not Subject to Deductible***
Primary Care Physician	Plan pays 75% after deductible	Plan pays 50% of allowable charges	You pay $30 per visit	You pay $25 per visit	You pay $30 per visit
Specialist	Plan pays 75% after deductible	Plan pays 50% of allowable charges	You pay $50 per visit	You pay $50 per visit	You pay $50 per visit
Preventative Care	***Not Subject to Deductible***		***Not Subject to Deductible***	***Not Subject to Deductible***	***Not Subject to Deductible***
Routine Exam- Adults	Plan pays 100% of allowable charges, including all tests	Plan pays 50% of allowable charges, including all tests	Plan pays 100%	Plan pays 100%	Plan pays 100%
Routine Exam-Children	Plan pays100% of allowable charges for at least 11 visits during1st 30 months of age, then 1 visit every year through age 18	Plan pays 50% of allowable charges for at least 11 visits during1st 30 months of age, then 1 visit every year through age 18	Plan pays 100%	Plan pays 100%	Plan pays 100%
Immunizations	Plan pays 100% of allowable charges	Plan pays 50% of allowable charges	Plan pays 100%	Plan pays 100%	Plan pays 100%
Diagnostic X-ray & Lab	Plan pays 75% after deductible	Plan pays 50% of allowable charges	Plan pays 100%; deductible does not apply	You pay $15 for lab work and $25 for x-rays; deductible does not apply	Plan pays 100% for lab work; you pay $50 for x-rays; deductible does not apply
CAT Scans & MRI's	Plan pays 75% after deductible	Plan pays 50% of allowable charges	You pay $100 per test after deductible	Plan pays 80% after deductible	You pay $100 per test: deductible does not apply
Durable Medical Equipment	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	Plan pays 100%; deductible does not apply	Plan pays 80% after deductible
Home Health Care	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible, up to 100 visits per calendar year	You pay $35 per visit; deductible does not apply; *prior authorization required*	You pay $50 per visit, up to 30 visits per calendar year, deductible does not apply
Chiropractic Care	Plan pays 100% after deductible, limit of 20 visits per year	Plan pays 75% of allowable charges after deductible, limit of 20 visits per year	You pay $50 per visit, up to 24 visits per calendar year; deductible does not apply	You pay $25 per visit, *referral required*, up to 20 visits per calendar year, deductible does not apply	You pay $50 per visit, up to 20 visits per calendar year/100 visits per lifetime; deductible does not apply

Physical Therapy	*Plan pays 75% after deductible; limit of 32 visits per year	*Plan pays 50% of allowable charges; limit of 32 visits per year	You pay $50 per visit, unlimited visits per calendar year; deductible does not apply	You pay $25 per visit; up to 60 days/visits per calendar year; deductible does not apply	You pay $30 per visit, up to 90 visits per calendar year for all 3 therapies; deductible does not apply
Speech Therapy	*Plan pays 75% of allowable charges after deductible	*Plan pays 50% of allowable charges	You pay $50 per visit, unlimited visits per calendar year; deductible does not apply	You pay $25 per visit, up to 60 days/visits per calendar year; deductible does not apply	You pay $30 per visit, up to 90 visits per calendar year for all 3 therapies; deductible does not apply
Maternity Care	Same as an illness except routine prenatal visits to a PPO provider paid at 100% with no deductible		Same as an illness except no co-pay for routine prenatal visits	Same as an illness except no co-pay for routine prenatal visits	Same as an illness except no co-pay for routine prenatal visits
Mental Health and Substance Abuse Care	**For substance abuse care, you may choose the Anthem Blue Cross PPO program, or the *Beat It!* Program**		**For substance abuse care, you may choose between coverage under the *Beat It!* Program or your HMO, or a combination of both**		
Inpatient	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Outpatient	*Plan pays 75% after deductible	*Plan pays 50% of allowable charges	You pay $20 per visit; deductible does not apply	You pay $25 per visit; deductible does not apply	You pay $30 per visit; deductible does not apply;
Prescription Drugs	**Must be obtained at an *ExpressScripts* Network pharmacy**		***Must be obtained at a participating HMO pharmacy***		
	Not Subject to Deductible		***Not Subject to Deductible***	***Not Subject to Deductible***	***Not Subject to Deductible***
Annual Out-of-Pocket Limit	Plan pays 100% after Rx co-pays reach $3,200 per year *($6,400 for a family)*		Included in Medical Out-of-Pocket Limit	Included in Medical Out-of-Pocket Limit	Included in Medical Out-of-Pocket Limit
Short Term *(outpatient)*	You pay $10 per generic, $30 per brand name, and $45 per non-preferred prescription, up to a 30-day supply		You pay $20 per formulary generic, $40 per formulary brand, and $60 per non-formulary prescription, up to a 30-day supply	You pay $20 per Tier I, $40 per Tier II, and $70 per Tier III prescription, up to a 30-day supply	You pay $20 per formulary generic, $40 per formulary brand, and $60 per non-formulary prescription, up to a 30-day supply
Maintenance (*30-day supply or more through the Mail Order)*	***ExpressScripts* Mail Order Pharmacy** - You pay $15 per generic, $45 per brand name and $68 per non-preferred prescription, up to a 90-day supply		**Mail Order -** You pay $50 per formulary generic, $100 per formulary brand, and $150 per non-formulary prescription, up to a 90-day supply	**Mail Order -** You pay $50 per Tier I, $100 per Tier II, and $175 per Tier III prescription, up to a 90-day supply	**Mail Order -** You pay $40 per formulary generic, $80 per formulary brand, and $120 per non-formulary prescription, up to a 90-day supply
Hearing Aids	Plan pays 100% up to $2,000 per device; one device for each ear every 3 years; deductible does not apply		Plan pays 80% after deductible; maximum benefit of $2,500 every 3 years	Plan pays 100%; limited to a single purchase of a type of hearing aid, including repairs & replacement once every 3 years; deductible does not apply	**Not Covered**
Emergency Room Care	You pay a $75 co-pay per Emergency Room visit, plus the balance due after the remaining expenses have been processed according to the regular Plan benefits, subject to the calendar year deductible and co-insurance percentages. The $75 co-pay is waived if admitted to the hospital. Benefits will be paid only if the condition fits the Plan's definition of emergency – refer to your Summary Plan Description booklet for details		You pay $250 per visit after deductible	You pay $250 per visit, plus 20% of EME, ($250 co-pay waived if admitted); deductible does not apply	You pay $250 per visit; deductible does not apply

THIS IS ONLY A SUMMARY: The above Plan benefits show only a partial summary of benefits. Please refer to the applicable Evidence of Coverage (EOC) booklet or Summary Plan Description booklet for prior-authorization requirements and specific restrictions, exclusions, and limitations.

Regardless of which medical plan you select, **your Dental, Vision, Death Benefits, and Accidental Death & Dismemberment Benefits** will continue to be provided by the Trust Fund**.**

Questions?

For ***Specific Benefits*** available, please call the appropriate Member Service numbers indicated below:

Anthem Blue Cross	800-888-8288
Health Plan of Nevada HMO Plan	800-777-1840
Kaiser Permanente Nevada HMO Plan (Formerly Hometown Health)	775-982-5000
United Healthcare Choice EPO Plan	800-377-5154

For information on specific benefits under the **Fee-for-Service/PPO Plan**, you may contact the **Health Department** of the Administrative Office, at **800-947-4338, option 1**.

For information on your ***Eligibility*** or ***Hour Bank*** status, or if you are not sure which plan you are currently enrolled on, please contact the **Health Department** of the Administrative Office, at **800-947-4338, option 3.**

Moving?

Please contact the Eligibility Department at the Administrative Office *immediately* if you change your mailing address! If you are enrolled in an HMO, ***a change of residence could result in a lapse of coverage!***

Please review and retain this Summary for future use. It contains the most current information on the plans available, as well as the current benefits effective January 1, 2027. All benefits are subject to change.



Sheet Metal Workers' Health Plan
of Southern California, Arizona & Nevada

P.O. Box 10067
Manhattan Beach, CA 90266
phone 800-947-4338 *or* 310-798-6572
fax 310-798-0766
smbpac.org

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Sheet Metal Workers' Health Plan
of Southern California, Arizona & Nevada

January 2027

Summary Comparison

of

Dental Plan Options

Plan A

Includes the pre-paid dental plan available in

Nevada

To ensure the best coverage is available for you and your eligible dependents, please review this comparison very carefully. **Once you have elected a dental plan, you may change your election only during the next Annual Open Enrollment.** Exceptions are made only if you move outside of your selected plan's service area, so please ***choose carefully***.

All completed enrollment forms received by the 15th of the month are processed for an effective date of the 1st day of following month.

Aviso a los participantes que hablan español: Si tiene alguna pregunta por favor no dude en comunicarse con la Oficina Administrativa al 800-947-4338, donde habrá varios representantes bilingües que con gusto le ayudarán.

Procedures	**DeltaCare USA** *Pre-paid DMO Plan*	**Delta Dental Premier®**
Important Information about each Plan	**Each family member must select a participating DeltaCare USA dentist from their provider directory and have all dental services performed by that dentist**. (Each member must designate a primary dentist.) If you go to a dentist other than your selected network dentist, you and/or your dependents will have no coverage for those services rendered, except for certain dental emergencies. There are no claim forms to fill out, and the Trust Fund pays DeltaCare directly for your dental care needs.	Benefits are paid based on *contract allowances*. **You may visit any licensed dentist**, but when you visit a Delta Dental Premier dentist, you are assured that his/her fees are based on contracted fees. If you visit a non-Delta Dental dentist, you must pay the difference between the dentist's fee and the contracted fee. Members visiting a non-Delta Dental dentist are responsible for submitting claims directly to Delta Dental for processing. Any plan reimbursement is paid to member.
Calendar Year Deductible	None	$50 per person; $150 per family Deductible does not apply to diagnostic and preventive benefits.
Annual Maximum	None	$3,000 per person
Diagnostic Oral examination Full mouth X-rays Bitewing X-rays Emergency treatment (Palliative)	 No cost No cost No cost $5 copay	Delta Dental pays 100% of the contract allowance.
Preventive Prophylaxis Topical fluoride Space maintainers Sealants – per tooth	 No cost No cost $10 copay $5 copay per tooth	Delta Dental pays 100% of the contract allowance. For Sealants- Delta Dental pays 80% of the contract allowance (*deductible applies).*
Periodontics Scaling and root planning Gingivectomy Muco-gingival or osseous surgery	 No cost Co-payments range $50 to $80 Copayments range $140 to $175	Delta Dental pays 80% of the contract allowance.
Endodontics Pulp capping Pulpotomy Root canals Apicoectomy - per root	 No cost No cost Co-payments range $90 to $205 No cost	Delta Dental pays 80% of the contract allowance.
Restorative *(other than crowns)* Amalgam Resin-based composite	 No cost Co-payments range no cost to $75	Delta Dental pays 80% of the contract allowance.
Crowns and Bridges Crowns Bridges Post and core	 Co-payments range from $35 to $195 Co-payments range from no cost to $195 No cost	Delta Dental pays 80% of the contract allowance.
Prosthodontics Dentures – Complete, Partials Dentures – Adjustments Denture reline *(office)* Denture rebase Implants	 Co-payments range from $80 to $170 No cost Co-payments range from $0 to $35 $35 co-payment Co-payments range from $345 to $1,005	Delta Dental pays 80% of the contract allowance.
Oral Surgery Simple extractions Surgical extractions Frenectomy	 No cost Co-payments range from $15 to $90 No cost	Delta Dental pays 80% of the contract allowance.
Orthodontia Limited Transitional Comprehensive Retention Records fee	(Child to age 19/adult) $950/$1,150 $950/$950 $1,700/$2,190 You pay $275 You pay $200	Delta Dental pays 80% of the contract allowance, up to $1,000 lifetime maximum *(child or adult).*
TMJ Rider	*n/a*	Delta Dental pays 80% of the contract allowance, up to $1,000 lifetime maximum.
Emergency Out-of-Area Treatment	Enrollee will be reimbursed up to $100 per emergency.	Benefits are payable as indicated above.

Important: This is not a contract. This is a *summary* of the dental plan options available to you. The group agreements and Plan documents must be consulted to determine the exact terms and conditions of coverage. All benefits are subject to change.

Questions?

For ***Specific Benefits*** available, please call the appropriate Member Service numbers indicated below:

Delta Dental Premier (800)-765-6003
Group # 5291-2901-NV

DeltaCare USA DMO (800)-422-4234
Group # 78705-0001-NV

Please review and retain this Summary for future use. It contains the most current benefit information on the plans available, as well as the current benefits effective January 1, 2027. All benefits are subject to change.



Sheet Metal Workers' Health Plan
of Southern California, Arizona & Nevada
P.O. Box 10067
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mm 10/26

Sheet Metal Workers' Health Plan of Southern California, Arizona & Nevada
P.O. Box 10067, Manhattan Beach, CA 90266-8567
Phone (800) 947-4338 Fax (310) 798-0766
Attn: Eligibility Dept.

Participant Data Form

Please Review, Complete (print) and Sign and Date <u>both sides</u> of this Form.
Incomplete forms will be returned to you, and may result in a delay of benefits.

☐ New Member ☐ Add / Delete Dependent ☐ Change Address ☐ Change Beneficiary

Name:	Date of Birth:	Social Security Number:
Street Address:		Local Union #
City, State, Zip		Home Phone #:
Email:	Cell Phone#:	
Employer	Classification	Hire Date
☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced	
Spouse's Employer & City	Spouse's Insurance Co.& City	

List Below all Eligible Dependents (including spouse, if married)
If adding or deleting a dependent, you <u>must</u> submit copies of legal proof of relationship with this form.

Last Name	First Name	MI	Social Security Number	Eligible for Medicare?	Date of Birth	Relationship

Death Benefit Beneficiary (Under the Health Plan)

Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship
Complete Address:					

Signature ***Date***

Please also Read, Sign and Date the Reverse →

* IMPORTANT *

Dependents of participants are eligible for coverage if they meet the rules below and the required documentation of dependent status is submitted to the Administrative Office.

Under the Active Plans, eligible dependents include the participant's:

- ► legal spouse (**former spouses are not eligible after the effective date of the dissolution of marriage or final divorce decree**);
- ► children under 26 years of age;
- ► an unmarried dependent child 26 years of age or older if the child is solely dependent upon the participant for support and is totally prevented from earning a living because of a mental or physical disability. The disabled child must have been disabled while covered under the Plan prior to reaching the limiting age of 26. Alternatively, within the five year period preceding the time the participant began accruing an hour bank leading to the participants' coverage under this Plan, the disabled child must have been disabled while covered under a related multi-employer health plan covering sheet metal workers employed under a collective bargaining agreement with a Sheet Metal Workers International Association local union, prior to reaching the limiting age of 26. The disability must be certified by a Physician and such certification must be submitted to the Administrative Office annually.

Children include the participant's natural child, legally adopted child, child "placed for adoption" if under 18 years old, or any other child for whom, by a Court Order of Legal Guardianship, or Qualified Medical Child Support Order (QMCSO), the participant is legally responsible for the child's health care expenses. Refer to the "Definitions" section of your Plan booklet for a description of a QMCSO. A child is "placed for adoption" (as stated above) with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Newly acquired eligible dependents must be enrolled within 31 days from the date dependency status is met. Otherwise, the dependent's coverage effective date may be delayed until the first of the month following the date the Administrative Office received the required documentation.

You must IMMEDIATELY notify the Administrative Office, in writing, when dependent status changes occur. This includes final dissolution of marriage, death, and any other events which would make your dependent not eligible for further coverage. **If claims and/or premiums are paid for any dependent spouse or child and it is later found that the dependent was not eligible, you and/or the dependent are responsible for reimbursing the Plan for any benefits and/or premiums paid, plus interest, and any costs and attorney's fees if a lawsuit must be filed to recover any benefits overpaid.**

Dependents who no longer meet the rules of the Plan may be entitled to continue coverage on a self-pay basis, in accordance with the rules and regulations of COBRA. Please refer to the Summary Plan Description for complete details.

Copies of the following documentation MUST be included with this Form in order to add / delete dependents:

Spouse - a copy of your Marriage Certificate **Ex-spouse -** a copy of your divorce decree

Children - a copy of their Birth Certificate and/or Court Orders. For newborns, please submit a copy of the hospital's *Verification* or *Certification of Birth* as soon as possible.

Enclosed are copies of all necessary documents. I hereby certify that the foregoing statements, including any accompanying statements and documents are true, correct, and complete to the best of my knowledge. I understand that incomplete Data Forms will be returned to me, and eligibility for benefits on dependents will not be verified until the proper documents are received in the Administrative Office. I also understand that I must immediately notify the Administrative Office, in writing, when dependent status changes occur.

_____ _____

Signature ***Date***

SHEET METAL WORKERS' PENSION PLAN OF SOUTHERN CALIFORNIA, ARIZONA AND NEVADA
Mailing address: P.O. Box 10067, Manhattan Beach, CA 90266 / Phone: (800) 947-4338

Designation of Beneficiary for Pre-Retirement Death Benefits – for Active (Non-Retired) Plan Participants

If you die before retirement, earned sufficient Pension Credit to be eligible for pension benefits, and are married at the time of death, your surviving spouse will receive 50% Survivor Annuity benefits for his or her lifetime after your death (provided you were married at least one year at the time of your death). If you are not married, or were married less than one year when you die, then your designated beneficiary or beneficiaries will receive 40 monthly payments of your Normal Retirement Age single life pension benefit. If your primary beneficiary dies before receiving all payments, your alternate beneficiary will receive the remaining payments. If you do not designate a beneficiary, or if the designated beneficiary or beneficiaries die before receiving all payments, remaining payments will be made to your legal beneficiary or beneficiaries in accordance with applicable law, in the following order: children, parents, siblings, and legal estate. If there are no remaining beneficiaries, benefits will cease.

Under Plan rules effective January 1, 2015, pre-retirement death benefits are not payable if the deceased participant is married at the time of death and his or her surviving spouse is eligible for 50% Survivor Annuity benefits, or if the deceased participant is an "**inactive vested**" participant at the time of death, or if the deceased participant worked in "**non-covered sheet metal service**" during the year of death or either of the two preceding years.

First Name _____ Last Name _____ Social Security Number _____ Telephone Number _____

Address _____ (is this a new address? ☐ yes ☐ no) City _____ State _____ Zip _____

CERTIFICATION OF MARITAL STATUS

☐ **I AM NOT MARRIED** at this time.

☐ **I AM MARRIED,** and I understand that my beneficiary designation(s) herein apply only if 50% Survivor Annuity benefits are not payable to my eligible surviving spouse at the time of my death.

I, a participant in the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada (the "Plan") wish to designate a beneficiary to receive any Pre-Retirement Death Benefits that may become payable to a designated beneficiary in the event that I die before receiving pension benefits under the Plan. I understand that if I designate two or more beneficiaries in a particular class of beneficiaries (primary or alternate), and do not indicate the percentage of benefits ("Share Percentage") each is to receive, all such beneficiaries with unspecified share percentages will receive equal shares. I hereby designate the following beneficiary or beneficiaries:

PRIMARY BENEFICIARY (OR BENEFICIARIES)

Name of Primary Beneficiary: _____ Relationship: _____

Address of Primary Beneficiary: _____

Social Security Number: _____ Phone Number: _____ Share Percentage: _____

Please check box if beneficiary is a minor under the age of 18: ☐ Minor's Age: _____

Name of Minor's Parent/Legal Guardian: _____ Phone Number: _____

Address of Minor's Parent/Legal Guardian: _____

Please complete by signing the reverse, incomplete (unsigned & undated) forms are not valid

PRIMARY BENEFICIARY(IES) CONT'D

Name of Primary Beneficiary: _____ Relationship: _____

Address of Primary Beneficiary: _____

Social Security Number: _____ Phone Number: _____ Share Percentage: _____

Please check box if beneficiary is a minor under the age of 18: ☐ Minor's Age: _____

Name of Minor's Parent/Legal Guardian: _____ Phone Number: _____

Address of Minor's Parent/Legal Guardian: _____

ALTERNATE BENEFICIARY (OR BENEFICIARIES)

(In the event of death of Primary Beneficiary or Beneficiaries)

Name of Alternate Beneficiary: _____ Relationship: _____

Address of Alternate Beneficiary: _____

Social Security Number: _____ Phone Number: _____ Share Percentage: _____

Please check box if beneficiary is a minor under the age of 18: ☐ Minor's Age: _____

Name of Minor's Parent/Legal Guardian: _____ Phone Number: _____

Address of Minor's Parent/Legal Guardian: _____

Name of Alternate Beneficiary: _____ Relationship: _____

Address of Alternate Beneficiary: _____

Social Security Number: _____ Phone Number: _____ Share Percentage: _____

Please check box if beneficiary is a minor under the age of 18: ☐ Minor's Age: _____

Name of Minor's Parent/Legal Guardian: _____ Phone Number: _____

Address of Minor's Parent/Legal Guardian: _____

Name of Alternate Beneficiary: _____ Relationship: _____

Address of Alternate Beneficiary: _____

Social Security Number: _____ Phone Number: _____ Share Percentage: _____

Please check box if beneficiary is a minor under the age of 18: ☐ Minor's Age: _____

Name of Minor's Parent/Legal Guardian: _____ Phone Number: _____

Address of Minor's Parent/Legal Guardian: _____

Name of Alternate Beneficiary: _____ Relationship: _____

Address of Alternate Beneficiary: _____

Social Security Number: _____ Phone Number: _____ Share Percentage: _____

Please check box if beneficiary is a minor under the age of 18: ☐ Minor's Age: _____

Name of Minor's Parent/Legal Guardian: _____ Phone Number: _____

Address of Minor's Parent/Legal Guardian: _____

Any previous pre-retirement death benefits beneficiary designation I made is revoked. I reserve my right to revoke this designation at any time. If I am married, I do not need my spouse's approval to revoke this beneficiary designation.

Signature: _____ Date Signed: _____

(this form must be signed and dated in order to be valid)

Sheet Metal Workers' Health Plan
of Southern California, Arizona & Nevada
P.O. Box 10067 Manhattan Beach, CA 90266-8567
(800) 947-4338 or (310) 798-6572

Delta Dental PPO / Premier Plan Enrollment Form

Effective Date:_____

Group _____**#5291-0501 (CA)**
_____**#5291-2901 (NV)**

Name _____

Last four of SSN _____

Address _____

Phone _____

Date of Birth _____

☐ Male ☐ Female ☐ Single ☐ Married

Eligible Dependents:

Last Name	First	MI	Social Security Number	Date of Birth	Relationship

As a reminder- **Medical and Dental Plan selections may be changed only during the Annual Open Enrollment Period. Exceptions are made only if you move outside of your selected Plan's service area.**

_____ _____

Participant Signature *Date*

DELTA DENTAL

Keep smiling

Delta Dental PPO™



Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist



PPO



NON-PPO

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

West Virginia: Learn about our commitment to providing access to a quality dentist network at **deltadentalins.com/about/legal/index-enrollee.html**.

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HL_PPO #135419F (rev. 1/23)

Benefit Highlights: Delta Dental PPO ™

Plan Benefit Highlights for: Sheet Metal Workers Health Plan of Southern California, Arizona and Nevada
Group No: 05291 - 00501

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	**Delta Dental PPO dentists:** $50 per person / $150 per family each calendar year **Non-Delta Dental PPO dentists:** $75 per person / $225 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$3,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100%	80%
Basic Services Fillings, sealants and posterior composites	80%	50%
Endodontics (root canals) Covered Under Basic Services	80%	50%
Periodontics (gum treatment) Covered Under Basic Services	80%	50%
Oral Surgery Covered Under Basic Services	80%	50%
Major Services Crowns, onlays, cast restorations and TMJ	80%	50%
Prosthodontics Bridges, dentures and implants	80%	50%
Temporomandibular Joint (TMJ) Maximums	$1,000 Lifetime	$1,000 Lifetime
Orthodontic Benefits Adults and dependent children	80%	80%
Orthodontic Maximums	$1,000 Lifetime	$1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California	Customer Service	Claims Address
560 Mission St., Suite 1300 San Francisco, CA 94105	888-335-8227	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Revised 10/20/2025

DELTA DENTAL



Siga sonriendo

Delta Dental PPO™

Ahorre con la red PPO

Consulte a un dentista de la red PPO[1] para maximizar sus ahorros.[2] Estos dentistas han accedido a reducir sus cargos y a usted no se le cobrará más de la parte que le corresponde de la factura.[3] Encuentre un dentista de la PPO en **es.deltadentalins.com**.

Abra una cuenta en línea

Obtenga información sobre su plan consulte sus beneficios e información de elegibilidad, busque a un dentista de la red y más. Regístrese para obtener una cuenta en línea en **es.deltadentalins.com**.

No cargue con otra tarjeta de identificación

No tiene que llevar una tarjeta de identificación de Delta Dental a su consulta con el dentista. Simplemente proporcione al dentista su nombre, fecha de nacimiento y número de identificación de afiliado o número de seguro social. Si los miembros de su familia tienen cobertura en su plan, deberán proporcionar los datos de usted. ¿Prefiere llevar una tarjeta de identificación? Simplemente ingrese en su cuenta en línea, donde puede ver o imprimir su tarjeta haciendo clic en un botón.

Coordine la cobertura doble

Si tiene cobertura de dos planes, pida a su dentista que incluya la información de ambos planes en su reclamación, nosotros nos encargaremos de lo demás.

Entienda la transición de la atención

Por lo general, los procedimientos de múltiples etapas sólo están cubiertos por su plan actual si el tratamiento empezó después de la fecha de entrada en vigencia de la cobertura de su plan.[4] Encuentre esta fecha ingresando a su cuenta en línea.

Obtenga LASIK y descuentos en audífonos

Gracias al acceso al cuidado de la salud de la audición de Amplifon y QualSight, puede recibir importantes descuentos en procedimientos LASIK y en auxiliares auditios.[5] Para aprovechar estos descuentos, llame a QualSight al **855-248-2020** y a Amplifon al **888-779-1429**.

Ahorre con un dentista de la PPO



PPO



NO ES DE LA PPO

[1] En Texas, Delta Dental Insurance Company ofrece un plan de la organización de prestadores de servicios dentales (DPO, por sus siglas en inglés).

[2] Todavía puede consultar cualquier dentista con la licencia correspondiente, pero los costos que deberá cubrir podrían ser mayores si elige a un dentista que no sea de la organización de proveedores preferentes (PPO, por sus siglas en inglés). Los dentistas de la red reciben el pago de los cargos contratados.

[3] Usted es responsable de cualquier deducible correspondiente, cargo que supere el límite máximo anual o de por vida y de los cargos por servicios no cubiertos. Los dentistas que no son de la red podrían cobrar la diferencia entre sus tarifas regulares y el máximo asignado por Delta Dental en el contrato.

[4] Se aplica únicamente a los procedimientos que cubra su plan. Si comenzó el tratamiento antes de la fecha de entrada en vigencia de su cobertura, usted o su compañía de seguros anterior será responsable de pagar cualquier costo. Es posible que se apliquen excepciones a ciertos grupos o estados. Si usted actualmente está recibiendo un tratamiento activo de ortodoncia, podría ser elegible para continuar el tratamiento con Delta Dental PPO. Para obtener los detalles específicos sobre su plan, consulte la Evidencia de cobertura, el Resumen descriptivo del plan o el Contrato de servicios dentales grupales.

[5] Los servicios correctivos de la vista y los servicios de cuidado de la salud auditiva de Amplifon no son beneficios cubiertos por el seguro. Delta Dental le facilita el acceso al programa de servicios correctivos de la vista y de servicios de atención a la salud auditiva mediante la disponiblidad de tarifas preferentes para cirugía LASIK y para audífonos auditivos y otros servicios de la salud auditiva.

West Virginia: Conozca nuestro compromiso con proveer acceso a una red de dentistas de calidad en **es.deltadentalins.com/about/legal/enrollee.html**.

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HL_PPO_ES #135419.08 (06/25)

Información importante sobre beneficios: Delta Dental PPO™

Información importante sobre los beneficios del plan para: Sheet Metal Workers Health Plan of Southern California, Arizona and Nevada

N.º de grupo: 05291 - 00501

Elegibilidad	Para obtener detalles de elegibilidad, consulte la Evidencia/el Certificado de cobertura del plan (en el archivo de su administrador de beneficios, patrocinador del plan o empleador).			
Deducibles	**Dentistas de la Delta Dental PPO:** $50 por persona / $150 por familia cada año calendario **Dentistas que no son de Delta Dental:** $75 por persona / $225 por familia cada año calendario			
¿Los servicios de diagnóstico y prevención (D y P) y ortodoncia están exentos de deducibles?	Sí			
Límites máximos	$3,000 por persona cada año calendario			
¿Los servicios de D y P cuentan para el límite máximo?	Sí			
Periodos de espera	Servicios básicos Ninguno	Servicios mayores Ninguno	Prostodoncia Ninguno	Ortodoncia Ninguno

Beneficios y servicios cubiertos*	Dentistas de Delta Dental PPO**	Dentistas que no son de Delta Dental PPO**
Servicios de diagnóstico y prevención (D y P) Exámenes, limpiezas y radiografías	100 %	80 %
Servicios básicos Empastes, selladores y compuestos posteriores	80 %	50 %
Endodoncia (tratamientos de conducto) Con cobertura bajo los servicios básicos	80 %	50 %
Periodoncia (tratamiento de las encías) Con cobertura bajo los servicios básicos	80 %	50 %
Cirugía bucal Con cobertura bajo los servicios básicos	80 %	50 %
Servicios mayores Coronas, incrustaciones onlay, restauraciones de molde y ATM	80 %	50 %
Prostodoncia Puentes, dentaduras postizas e implantes	80 %	50 %
Límites máximos de la articulación temporomandibular (ATM)	$1,000 de por vida	$1,000 de por vida
Beneficios de ortodoncia Adultos e hijos dependientes	80 %	80 %
Límites máximos de los beneficios de ortodoncia	$1,000 de por vida	$1,000 de por vida

* Pueden aplicarse limitaciones o periodos de espera para algunos beneficios. Algunos servicios pueden estar excluidos de su plan. El reembolso se basa en los valores autorizados en el contrato de Delta Dental y no necesariamente en los cargos reales de cada dentista.

** El reembolso se basa en las tarifas contratadas de la red PPO para dentistas de la red PPO, las tarifas contratadas de la red Premier para dentistas de la red Premier y la asignación del programa para dentistas que no pertenecen a Delta Dental.

Delta Dental of California
560 Mission St., Suite 1300
San Francisco, CA 94105

Servicio al Cliente
888-335-8227

Dirección para reclamaciones
P.O. Box 997330
Sacramento, CA 95899-7330

es.deltadentalins.com

Esta información sobre los beneficios no reemplaza ni sirve como Evidencia de cobertura ni Resumen descriptivo del plan. Si tiene preguntas específicas respecto de los beneficios, las limitaciones o las exclusiones de su plan, consulte al representante de beneficios de su empresa.

DELTA DENTAL

DeltaCare® USA

Elevate Your Smile

8 ways to make the most of your dental plan



1 Visit your DeltaCare USA dentist. You must visit your selected DeltaCare USA primary care dentist to receive benefits under your plan.[1] Find or change your dentist[2] at **deltadentalins.com** or by calling Customer Service.

- You don't need a dental plan ID card when you visit the dentist. Simply provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need to provide your information.
- There are no claims forms to complete — just pay your copayment, if any, at the time of treatment.[3]
- If you require treatment from a specialist, your primary care dentist will coordinate a referral for you.[4]

2 Seek preventive care. Regular exams and cleanings are available at low or no cost. These services help catch problems before they require costly and extensive treatment.

3 Set up an online account. Get information about your plan anytime, anywhere by signing up for an Online Services account. This free service lets you find a network dentist, view or print your ID card and more. The one-time registration process takes only a minute.

Newly covered?

Visit **deltadentalins.com/welcome**

[1] In WY, you do not need to select a primary care dentist, but you must visit a DeltaCare USA dentist to receive benefits. In the following states, you can maximize your savings when you visit a DeltaCare USA dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

[2] Changes received by the 21st of the month will be effective the first day of the following month. Verify that the dentist is your selected DeltaCare USA primary care dentist before each appointment. In the following states, you can change your dentist any time without contacting Delta Dental: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT, WY.

[3] You may have to complete a claim form if you visit an out-of-network dentist, such as for limited emergency treatment or in the following states: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT.

[4] Most services not performed by your primary care dentist must be authorized by Delta Dental. In some states, specialty care benefits are only available for services performed by a DeltaCare USA specialist. Refer to your plan booklet for more information.

We keep you smiling®

deltadentalins.com/enrollees

4 **Get to know your plan.**
Many DeltaCare USA plans have no exclusions for pre-existing conditions, including missing teeth.[5] Read your plan booklet for a complete list of covered procedures, copayments, plan limitations and exclusions.

5 **Coordinate benefits.**
Are you covered under a second dental plan? Ask your dentist to include information about both plans with your claim, and we'll handle the rest.[5]

6 **Complete in-progress orthodontic care.**
If you began orthodontic treatment under a previous employer-sponsored plan, you may be covered for continuing treatment with your current orthodontist. The copayments and fees of your previous plan would apply.[5]

7 **Talk to your dentist.**
From pregnancy to diabetes, overall health can affect your dental health. Start each visit with a quick chat about any issues.

8 **Stay informed.**
Get oral health tools and tips at our SmileWay® Wellness site (**mysmileway.com**). Don't forget to subscribe to *Grin!*, our free dental wellness e-magazine.

[5] This provision may not apply to all plans. Please refer to your plan booklet for specific coverage details.

Contact us

Online assistance:

For quick and easy online assistance, go to **deltadentalins.com** > **Contact Us**, select the Delta Dental company and choose the applicable customer service form.

Telephone assistance:

DeltaCare USA: **800-422-4234 (toll-free)**

- Use our interactive voice response system, available 24/7. You can check your coverage levels, remaining maximum and more.
- Speak to a Customer Service representative: Monday – Friday, 8 a.m. – 9 p.m. Eastern time.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA - Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html.

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Blue View Vision℠
FS.B.15.0.120.120
Sheet Metal Workers Health Plans

Anthem

Welcome to your Blue View Vision plan!
You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

Your vision plan includes coverage for routine eye exams and prescription eyewear from your choice of eye care providers.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$15 Copay	Reimbursed Up To $45	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$120 Allowance, then 20% off any remaining balance	Reimbursed Up To $47	Once every 24 months
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses			
○ Single vision lenses	$0 Copay	Reimbursed Up To $45	Once every 12 months
○ Bifocal lenses	$0 Copay	Reimbursed Up To $65	
○ Trifocal lenses	$0 Copay	Reimbursed Up To $85	
○ Lenticular lenses	$0 Copay	Reimbursed Up To $125	
Eyeglass Lens Enhancements *When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost*			
○ Transitions Lenses (for a child under age 19)	$0 Copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
○ Standard polycarbonate (for a child under age 19)	$0 Copay		
○ Factory Scratch Coating	$0 Copay		
Contact Lenses *(instead of eyeglass lenses)* *Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*			
○ Elective conventional (non-disposable) OR	$120 Allowance, then 15% off any remaining balance	Reimbursed Up To $105	Once every 12 months
○ Elective disposable OR	$120 Allowance *(no additional discount)*	Reimbursed Up To $105	
○ Non-elective (medically necessary)	Covered in full	Reimbursed Up To $210	
Low Vision Benefits (Low Vision benefits are only available when you use an Network Provider)			
Comprehensive Low Vision Eye Exam A Low Vision Eye Exam is in lieu of a Routine Eye Exam.	$15 Copayment	Not Covered	Once every 12 months
Supplemental Care Aids and Supplemental Testing Examination	$1,000 maximum allowance	Not Covered	Once every 12 months

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing

Contract code: 0BD8

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY (Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage.)		In-Network Member Cost (after any applicable copay)
Retinal Imaging - at member's option, can be performed at time of eye exam		Not More Than $39
Eyeglass lens upgrades When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	○ Standard Polycarbonate (Adults) ○ Tint (Solid and Gradient) ○ UV Coating ○ Progressive Lenses[1] ○ Standard ○ Premium Tier 1 ○ Premium Tier 2 ○ Premium Tier 3 ○ Anti-Reflective Coating[2] ○ Standard ○ Premium Tier 1 ○ Premium Tier 2 ○ Other Add-ons (i.e. high index lenses, anti-fog coating)	$40 $0 $15 $65 $85 $95 $110 $45 $57 $68 20% off retail price
Additional Pairs of Eyeglasses **Anytime from any Blue View Vision network provider**	○ Complete Pair ○ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	○ Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail
Conventional Contact Lenses **(non-disposable type)**	○ Discount applies to materials only ○	15% off retail price
Contact lens fit and follow-up **A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.**	○ Standard contact lens fitting3 ○ Premium contact lens fitting4	Up to $55 10% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available anti-reflective brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations.

Some of our in-network providers include:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

Online stores:

GLASSES.COM glasses.com | contactsdirect contactsdirect.com | 1800contacts 1800contacts.com | LENSCRAFTERS lenscrafters.com | TARGET OPTICAL targetoptical.com | Ray-Ban ray-ban.com/insurance

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at **anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 .to request a claim form.

TO FAX: 866-293-7373
TO EMAIL: ooncclaims@eyewearspecialoffers.com
TO MAIL: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

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Blue View Vision℠
FS.B.15.0.120.120
Sheet Metal Workers Health Plans

Anthem

¡Le damos la bienvenida al plan Blue View Vision!
Tiene muchas opciones a la hora de usar sus beneficios. Como miembro del plan Blue View Vision, tiene acceso a una de las redes de atención de la vista más grandes del país. Puede elegir entre muchos médicos de práctica privada, ópticas locales y tiendas minoristas nacionales como LensCrafters®, Target Optical® y casi todas las sucursales de Pearle Vision®. También puede emplear los beneficios dentro de la red para realizar el pedido en línea de artículos para la vista en Glasses.com y en ContactsDirect.com. Si desea encontrar una sucursal o un oftalmólogo participante de la red, inicie sesión en **anthem.com**, o en el menú de la página principal, en la sección Care (Atención), seleccione **Find a Doctor** (Encontrar un médico). También puede comunicarse con Servicios para Miembros para recibir asistencia al **1-866-723-0515**.

Fuera de la red – Si lo prefiere, puede recibir sus beneficios cubiertos fuera de Blue View Vision. Simplemente, pague el total del servicio en el momento de recibirlo, obtenga un recibo detallado y presente una reclamación de reembolso hasta el monto de su asignación máxima para servicios fuera de la red.

Su plan de la vista incluye cobertura para exámenes oculares de rutina y anteojos recetados de su elección de proveedores de atención de los ojos.

SUS BENEFICIOS DEL PLAN BLUE VIEW VISION	DENTRO DE LA RED	FUERA DE LA RED	FRECUENCIA
Examen oftalmológico de rutina			
Examen de visión integral	Copago de $15	Reembolso de hasta $45	Una vez cada 12 meses
Marcos de anteojos			
Un par de marcos de anteojos	Asignación de $120 y luego descuento del 20% en el saldo restante	Reembolso de hasta $47	Una vez cada 24 meses
Lentes para anteojos *(en lugar de lentes de contacto)*			
Un par de lentes recetados de plástico estándar			
○ Lentes unifocales	Copago de $0	Reembolso de hasta $45	Una vez cada 12 meses
○ Lentes bifocales	Copago de $0	Reembolso de hasta $65	
○ Lentes trifocales	Copago de $0	Reembolso de hasta $85	
○ Lentes lenticulares	Copago de $0	Reembolso de hasta $125	
Mejoras de lentes para anteojos *Por el hecho de obtener lentes o anteojos que están cubiertos por un proveedor de Blue View Vision, puede añadir (sin ningún costo adicional) cualquiera de las siguientes mejoras de lentes.*			
○ Lentes Transitions (para un niño menor de 19)	Copago de $0	Sin asignación si se obtuvieron fuera de la red	Igual que para lentes para anteojos cubiertos
○ Policarbonato estándar (para un niño menor de 19)	Copago de $0		
○ Revestimiento antirrayaduras de fábrica	Copago de $0		
Lentes de contacto *(en lugar de lentes para anteojos)* *La asignación para lentes de contacto solamente se aplicará a la primera compra de lentes de contacto que realice durante un periodo de beneficios. Cualquier monto restante no utilizado no podrá utilizarse para compras posteriores durante el mismo periodo de beneficios ni podrá transferirse al siguiente periodo de beneficios.*			
○ Optativos convencionales (no descartables) O BIEN	Asignación de $120 y luego descuento del 15% en el saldo restante	Reembolso de hasta $105	
○ Optativos descartables O BIEN	Asignación de $120 *(sin descuentos adicionales)*	Reembolso de hasta $105	Una vez cada 12 meses
○ No optativos (necesarios por motivos médicos)	Cobertura total	Reembolso de hasta $210	

Código de contrato: 0BD8

Beneficios para vista deficiente (Los beneficios para la vista deficiente solo están disponibles cuando usa un proveedor de la red)

Examen oftalmológico integral por vista deteriorada Un examen oftalmológico por vista deteriorada en lugar de un examen oftalmológico de rutina.	Copago de $15	Sin cobertura	Una vez cada 12 meses
Dispositivos de asistencia complementaria y pruebas complementarias	Asignación máxima de $1,000	Sin cobertura	Una vez cada 12 meses

Este es un beneficio primario de atención de la vista que tiene como objeto cubrir, solamente, los exámenes de la vista de rutina y los lentes y anteojos correctivos. Blue View Vision es solamente para la atención de los ojos de rutina. Si necesita tratamiento médico para los ojos, visite a un oftalmólogo participante de su red médica. Los beneficios son pagaderos, exclusivamente, por los gastos realizados mientras la cobertura grupal y de la persona asegurada estén en vigor. Esta información es, simplemente, una breve descripción de la cobertura. Todos los términos y las condiciones de la cobertura, incluso los beneficios y las exclusiones, se encuentran en la póliza del miembro, la cual prevalecerá en caso de discrepancia con esta descripción general. Esta descripción general de los beneficios es parte del paquete completo de inscripción.

EXCLUSIONES Y LIMITACIONES (esta no es una lista completa, consulte el Certificado de cobertura del miembro para obtener una lista completa)

Ofertas combinadas. No se pueden combinar con ninguna oferta, cupón o promoción de una tienda.
Montos excedentes. Todo monto que sobrepase los gastos de la vista cubiertos.
Anteojos de sol. Lentes de sol planos y marcos accesorios.
Anteojos de seguridad. Anteojos de seguridad y marcos accesorios.
Servicios sin especificar. Servicios no mencionados específicamente en el plan como servicios cubiertos.
Marcos y lentes rotos o perdidos. Ningún marco o lente que se haya roto o perdido puede ser reemplazado, a menos que la persona asegurada haya alcanzado el plazo de servicio normal, tal como se indica en las estipulaciones del plan.
Lentes de venta sin receta. Anteojos, lentes o lentes de contacto no recetados. Lentes Plano o lentes que no tienen efecto refractivo.
Ortóptica. Ortóptica o entrenamiento de la vista y cualquier prueba complementaria relacionada.

AHORROS OPCIONALES DISPONIBLES EXCLUSIVAMENTE CON PROVEEDORES DENTRO DE LA RED BLUE VIEW VISION (Los descuentos no son "beneficios cubiertos" en su plan de atención de la vista y no figurarán en su Certificado de cobertura).		**Costo para miembros dentro de la red** (después del copago correspondiente)
Estudios por imágenes de retina: a opción del miembro, se pueden realizar en el momento del examen oftalmológico.		No más de $39

Mejoras de lentes para anteojos
En el momento de obtener artículos para la vista de un proveedor de Blue View Vision, puede optar por mejorar los lentes de los anteojos a un precio con descuento. Se aplica un copago para los lentes para anteojos.
	○ Policarbonato estándar (adultos)
	○ Tinte (parejo y gradual)
	○ Protección contra rayos UV
	○ Lentes progresivos[1]
	  ○ Estándar
	  ○ Nivel 1 premium
	  ○ Nivel 2 premium
	  ○ Nivel 3 premium
	○ Revestimiento antirreflejante[2]
	  ○ Estándar
	  ○ Nivel 1 premium
	  ○ Nivel 2 premium
	○ Otros accesorios (p. ej., lentes de alto índice, revestimiento antiniebla)
		$40
		$0
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		Descuento del 20% en el precio minorista

Par de anteojos adicional **En todo momento de cualquier proveedor de la red Blue View Vision.**	○ Par completo ○ Materiales de los anteojos que se compran por separado	Descuento del 40% en el precio minorista Descuento del 20% en el precio minorista
Accesorios de lentes y anteojos	○ Productos tales como anteojos de sol sin receta, artículos de limpieza para lentes, soluciones para lentes de contacto, estuches para anteojos, etc.	Descuento del 20% en el precio minorista
Lentes de contacto convencionales (no descartables)	○ El descuento se aplica solo a los materiales	Descuento del 15% en el precio minorista
Ajuste de lentes de contacto y seguimiento **Está disponible un ajuste de lentes de contacto y dos visitas de seguimiento una vez que haya completado un examen oftalmológico integral.**	○ Ajuste de lentes de contacto estándar[3] ○ Ajuste de lentes de contacto premium[4]	Hasta $55 Descuento del 10% en el precio minorista

[1] Solicite recomendaciones a su proveedor, además de marcas de lentes progresivos disponibles por niveles.

[2] Solicite recomendaciones a su proveedor, además de marcas de lentes antirreflejantes disponibles por niveles.

[3] El ajuste estándar incluye los lentes transparentes esféricos de uso convencional y de reemplazo programado. Los ejemplos incluyen, entre otros, lentes desechables y de reemplazo frecuente.

[4] El ajuste premium incluye todos los diseños, materiales y ajustes de especialidad que no se incluyen en los lentes de contacto estándar. Los ejemplos incluyen, entre otros, lentes tóricas y multifocales.

No se puede combinar con ninguna otra oferta. Los descuentos están sujetos a cambios sin aviso previo. Los descuentos no son beneficios cubiertos en su plan de atención de la vista y no figurarán en su certificado de cobertura. Los proveedores dentro de la red ofrecerán descuentos en productos y servicios, excepto cuando las leyes estatales impidan los descuentos en productos o servicios que no son beneficios cubiertos por este plan. Los descuentos en marcos no serán aplicables si el fabricante impone una política de no aplicación de descuentos sobre ventas en sitios de venta minorista o sucursales de proveedores independientes.

Algunos de los proveedores dentro de la red son los siguientes:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

Online stores:

GLASSES.COM glasses.com | contactsdirect contactsdirect.com | 1800contacts 1800contacts.com | LENSCRAFTERS lenscrafters.com | TARGET OPTICAL targetoptical.com | Ray-Ban ray-ban.com/insurance

AHORROS ADICIONALES DISPONIBLES A TRAVÉS DE NUESTRO PROGRAMA DE OFERTAS ESPECIALES DE ANTHEM

Una vez que haya utilizado sus beneficios, usted cuenta con ahorros disponibles en artículos, como anteojos adicionales, anteojos de sol sin receta, audífonos e incluso la cirugía de corrección de la vista con láser LASIK a través de una variedad de proveedores. Simplemente inicie sesión en **anthem.com**, seleccione descuentos, y luego Vision, Hearing & Dental (Visión, audición y dental).

* Los descuentos no pueden utilizarse junto con sus beneficios cubiertos.

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Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Es importante que lo tratemos de forma justa
Es por eso que acatamos las leyes federales de derechos civiles en nuestros programas y actividades relacionados con la salud. No discriminamos, excluimos a personas ni las tratamos de manera diferente por su raza, color, origen nacional, sexo, edad ni discapacidad. Para las personas con discapacidades, ofrecemos ayuda y servicios gratuitos. También ofrecemos servicios gratuitos de asistencia en otros idiomas a través de intérpretes y otros idiomas escritos para las personas cuya lengua materna no sea el inglés. ¿Le interesan estos servicios? Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda (TTY/TDD: 711). Si usted considera que no hemos brindado estos servicios o que lo hemos discriminado por cuestiones de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja o un reclamo. Puede presentar un reclamo a nuestro coordinador de cumplimiento por escrito a Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. O bien, puede presentar un reclamo ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU., ubicada en 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201, llamar al 1-800-368-1019 (TDD: 1-800-537-7697) o visitar https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Los formularios de reclamos están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

Obtenga ayuda en su idioma

¿Quiere saber lo que significa todo esto? Nosotros también querríamos saberlo. Esta es la versión en inglés: You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Además de nuestro programa de asistencia en otros idiomas, ponemos a disposición de los miembros con problemas visuales documentos en formatos alternativos. Si necesita una copia de este documento en otro formato, llame al número telefónico de Servicio de Atención al Cliente que figura en el dorso de su tarjeta de identificación.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. **(TTY/TDD: 711)**

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید.(TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें।(TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។(TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

FUERA DE LA RED

Si opta por recibir servicios cubiertos o adquirir artículos para la vista con cobertura de un proveedor fuera de la red, no se aplicarán descuentos de la red y usted deberá pagar los servicios y/o los materiales de los artículos para la vista al momento de recibir el servicio. Complete un formulario de reclamaciones fuera de la red y envíelo junto con su recibo detallado al número de fax, dirección de correo electrónico o dirección postal que se encuentran más abajo. Para descargar un formulario de reclamaciones, inicie sesión en **anthem.com**, o desde el menú de la página principal, en la sección Support (Soporte), seleccione Forms (Formularios), haga clic en Change State (Cambiar estado) para elegir su estado y luego vaya a Claims (Reclamaciones) y seleccione Blue View Vision Out-of-Network Claim Form (Formulario de reclamaciones fuera de la red de Blue View Vision). Puede llamar a Servicios para Miembros al 1-866-723-0515 para solicitar un formulario de reclamaciones.

FAX:	866-293-7373
CORREO ELECTRÓNICO:	oonclaims@eyewearspecialoffers.com
CORREO POSTAL:	Blue View Vision Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111

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