

**CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA**

265 Hegenberger Road, Suite 100

P.O. Box 2280

Oakland, California 94621-0180

Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215

[www.carpenterfunds.com](http://www.carpenterfunds.com)



July 24, 2020

**To: All Retired Plan Participants and/or their Beneficiaries**

➤ *Indemnity & Kaiser / Non-Medicare*

**From: BOARD OF TRUSTEES**

**Carpenters Health and Welfare Trust Fund for California**

**Re: SUMMARY OF BENEFITS AND COVERAGE (SBC) required by the Affordable Care Act (ACA)**

As required by law, group health plans like ours are providing plan participants with a Summary of Benefits and Coverage (SBC) as a way to help understand and compare medical benefits. The SBC provides a brief overview of the medical plan benefits provided by the Carpenters Health and Welfare Trust Fund for California. Please share this SBC with your family members who are also covered by the Plan.

Each SBC contains concise medical plan information in plain language about benefits and coverage. This includes what is covered, what you need to pay for various benefits, what is not covered, and where to go for more information or to get answers to questions. Government regulations are very specific about the information that can and cannot be included in each SBC. The Plan is not allowed to customize much of the SBC. An SBC includes:

- A health plan comparison tool called “Coverage Examples.” These examples illustrate how the medical plan covers care for two common health scenarios: having a baby and diabetes care. These examples show the projected total costs associated with each of these two situations, how much of these costs the Plan covers and how much you, the participant, need to pay. In these examples, it’s important to note that the costs are national averages and do not reflect what the actual services might cost in your area. Plus, the cost for your treatment might also be very different depending on your doctor’s approach, whether your doctor is an In-Network PPO Provider or a Non-PPO Provider, your age and any other health issues you may also have. These examples are there to help you compare how different health plans might cover the same condition—not for predicting your own actual costs.
- A link to a “Glossary” of common terms used in describing health benefits, including words such as “*deductible*,” “*co-payment*,” and “*co-insurance*.” The glossary is standard and cannot be customized by a Plan.
- Websites and toll-free phone numbers you can contact if you have questions or need assistance with benefits.


Please keep this notice with your benefit booklet. If you have any questions, please call Benefit Services at the Trust Fund Office at (510) 633-0333 or toll free at (888) 547-2054. You may also send an email to [benefitservices@carpenterfunds.com](mailto:benefitservices@carpenterfunds.com)



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.carpenterfunds.com](http://www.carpenterfunds.com) or call 1-888-547-2054. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.carpenterfunds.com](http://www.carpenterfunds.com) or call 1-888-547-2054 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	Contract <u>Provider</u> : \$128/individual per calendar year; \$256/family per calendar year. Non-Contract <u>Provider</u> : \$257/person per calendar year; \$514/family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Mental health, chemical dependency (including detox), member assistance program visits, Contract <u>Provider</u> On-Line Health physician visits up to \$59 per visit, and outpatient <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	There is no <u>out-of-pocket limit</u> on all types of <u>cost sharing</u> , but there is a \$1,289/person (\$2,578/family) on the amount of <u>coinsurance</u> that you must pay for covered services in a year.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, hearing examination and hearing aid expenses, penalties for failure to obtain precertification, <u>deductibles</u> , expenses from Non-Contract <u>providers</u> , outpatient retail/mail order <u>prescription drug</u> expenses, amounts over the reference-based pricing allowances and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-888-547-2054 for a list of Contract <u>providers</u> in California. See <a href="http://www.bcbs.com">www.bcbs.com</a> or call 1-800-810-2583 for a list of Contract <u>providers</u> outside the state of California.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Services from Non-Contract providers not registered with CMS are limited to \$100/appointment.</li> </ul>
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services from Non-Contract providers not registered with CMS are limited to \$100/appointment.
	<u>Preventive care/screening/Immunization</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>For adults and children, benefits are limited to one routine physical exam in any 12-month period.</li> <li>For Employee and Spouse only, benefits include one routine Ob-Gyn examination within a 12-month period in addition to the routine physical. Coverage includes any x-rays and laboratory tests provided in connection with the physical examination, including a pap smear.</li> <li>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</li> <li>Services from Non-Contract providers not registered with CMS are limited to \$100/appointment.</li> </ul>
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Professional/physician charges may be billed separately (Services from Non-Contract providers not registered with CMS are limited to \$100/appointment). Precertification is required for CT/CTA, MRI, Nuclear Cardiology, Pet Scans and Echocardiography.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

\* For more information about limitations and exceptions, see the plan or policy document at [www.carpenterfunds.com](http://www.carpenterfunds.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call 1-800-939-7093.</p>	Generic drugs	Retail: \$15 <u>copay</u> /fill. Mail order: \$26 <u>copay</u> /fill	You pay 100% (unless there are no network pharmacies within 10 miles). <u>Plan</u> reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	<ul style="list-style-type: none"> <li>• Retail Pharmacy – 30-day supply</li> <li>• Mail Order Pharmacy – 90-day supply</li> <li>• <u>Deductible</u> does not apply to outpatient <u>prescription drugs</u>.</li> <li>• <u>Cost sharing</u> for outpatient <u>prescription drugs</u> <b>does not count</b> toward the <u>out-of-pocket limit</u>.</li> <li>• If the cost of the drug is less than the <u>copay</u>, you pay just the drug cost.</li> <li>• Some prescription drugs are subject to <u>preauthorization</u> (to avoid non-payment), or step therapy requirements.</li> <li>• Brand name Proton Pump Inhibitors (PPI) and Cholesterol drugs not covered.</li> <li>• For any new Brand Name Drug approved by the federal FDA, including injectable and infusion drugs, the <u>copay</u> is 50% of the cost of the drug for a minimum of 24 months after the drug has been approved. If the PBM determines that the new FDA-approved drug is a “must not add” drug, the <u>copay</u> will remain at 50% of the cost of the drug.</li> <li>• Mail Order is mandatory if more than 2 prescriptions are filled for maintenance medications.</li> </ul>
	Preferred brand drugs (Formulary brand drugs)	Retail: \$15 <u>copay</u> /fill + cost difference between generic and brand for multi-source brand. \$53 <u>copay</u> /fill for single-source formulary brand. Mail order: \$26 <u>copay</u> /fill + cost difference between generic and brand for multi-source brand. \$106 <u>copay</u> /fill for single-source formulary brand.		
	Non-preferred brand drugs (Non-formulary brand drugs)	Retail: \$80 <u>copay</u> /fill; Mail Order: \$133 <u>copay</u> /fill		
	<u>Specialty drugs</u>	Subject to Retail Copays (30-day supply).		
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u> plus any amounts over \$300	For certain out-patient surgeries, the Plan has a maximum benefit payable if services are done at a hospital facility instead of an ambulatory surgery center. To avoid Plan maximums, precertification is required for outpatient surgeries.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services from Non-Contract providers not registered with CMS are limited to \$100/appointment.

\* For more information about limitations and exceptions, see the plan or policy document at [www.carpenterfunds.com](http://www.carpenterfunds.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	<b>Medical:</b> 10% <u>coinsurance</u> . <b>Mental Health or Substance Abuse:</b> No charge	<b>Medical:</b> 30% coinsurance (10% coinsurance if no choice in hospital due to emergency). <b>Mental Health or Substance Abuse:</b> No charge	Professional/physician charges may be billed separately. (Services from Non-Contract providers not registered with CMS are limited to \$100/appointment).
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> .	Limited to emergency care or medically necessary inter-facility transfer to the nearest hospital, only. Services provided by an Emergency Medical Technician (EMT) without subsequent emergency transport are covered. *See Article 1 of the Plan Document for more information on emergency care.
	<u>Urgent care</u>	<b>Medical:</b> 10% <u>coinsurance</u> . <b>Mental Health or Substance Abuse:</b> No charge	<b>Medical:</b> 30% coinsurance (10% coinsurance if no choice in hospital due to emergency). <b>Mental Health or Substance Abuse:</b> No charge	Services from Non-Contract providers not registered with CMS are limited to \$100/appointment.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>• Precertification is required.</li> <li>• A maximum of \$30,000 is payable for the hospital facility charges associated with a single hip joint or knee joint replacement surgery.</li> <li>• In a Non-Contract Hospital, the <u>plan</u> covers a room with 2 or more beds (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used).</li> <li>• Services from Non-Contract providers not registered with CMS are not covered.</li> </ul>
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services from Non-Contract providers not registered with CMS are not covered.

\* For more information about limitations and exceptions, see the plan or policy document at [www.carpenterfunds.com](http://www.carpenterfunds.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Mental Health:</b> 10% coinsurance <b>Substance Abuse:</b> no charge, <u>deductible</u> does not apply	30% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Plan pays 100% for physician online visits with a Contract Provider.</li> <li>Services from Non-Contract providers not registered with CMS are limited to \$100/appointment.</li> </ul>
	Inpatient services	<b>Mental Health:</b> 20% coinsurance, <u>deductible</u> does not apply. <b>Substance Abuse:</b> no charge, <u>deductible</u> does not apply, for first rehab program, 10% <u>coinsurance</u> for subsequent programs.	30% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Precertification is required.</li> <li>In a Non-Contract Hospital, the <u>plan</u> covers a room with 2 or more beds (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used)</li> <li>Services from Non-Contract providers not registered with CMS are not covered.</li> </ul>
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).</li> <li>Services from Non-Contract providers not registered with CMS are limited to \$100/appointment</li> </ul>
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services from Non-Contract providers not registered with CMS are not covered.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification is required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. Services from Non-Contract providers not registered with CMS are not covered.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Services from Non-Contract providers not registered with CMS are limited to \$100/appointment.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<b>Outpatient:</b> Services from Non-Contract providers not registered with CMS are limited to \$100/appointment. <b>Inpatient:</b> Services from Non-Contract providers not registered with CMS are not covered.
	<u>Habilitation services</u>	Not covered	Not covered	You pay 100% for this service, even in-network.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification is recommended. Limited to 70 days per confinement. Services from Non-Contract providers not registered with CMS are not covered.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Rental covered up to reasonable purchase price.

\* For more information about limitations and exceptions, see the plan or policy document at [www.carpenterfunds.com](http://www.carpenterfunds.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<b>Outpatient:</b> Services from Non-Contract providers not registered with CMS are limited to \$100/appointment. <b>Inpatient:</b> Services from Non-Contract providers not registered with CMS are not covered. Covered if terminally ill. Respite care is limited to 8 days.
If your child needs dental or eye care	Children's eye exam	\$10 <u>copayment</u>	\$10 <u>copayment</u>	Vision benefits are available through a separate vision <u>plan</u> . Your <u>cost sharing</u> does not count toward the medical <u>plan's out-of-pocket limit</u> .
	Children's glasses	\$25 <u>copayment</u> , plus all amounts over \$175 for frames	\$25 <u>copayment</u> , plus all amounts over \$35 for single vision lenses and amount over \$45 for frames	
	Children's dental check-up	Not covered	Not covered	If you elect to purchase a Voluntary Dental Plan, it will be provided under a separate policy.

#### Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• <u>Habilitation services</u></li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (up to \$35/visit and 20 visits per calendar year)</li> <li>• Bariatric surgery (with precertification)</li> <li>• Chiropractic care (Employee and spouse only. Up to \$25/visit up to 20 visits per calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult) (except under a Voluntary Dental Plan)</li> <li>• Hearing aids (limited to \$800/ear in any 3-year period)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine eye care (Adult) (under separate vision plan)</li> <li>• Routine foot care</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [www.carpenterfunds.com](http://www.carpenterfunds.com).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Trust Fund Office at 1-888-547-2054. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

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

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-547-2054.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-547-2054.

Chinese (中文): 如果需要中文的帮助, □ □ □ □ □ □ □ 1-888-547-2054.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

\* For more information about limitations and exceptions, see the plan or policy document at [www.carpenterfunds.com](http://www.carpenterfunds.com).





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

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$128
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:  
Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$128
Copayments	\$90
Coinsurance	\$1,240
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$1,468</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$128
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$128
Copayments	\$580
Coinsurance	\$290
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,058</b>

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

- The plan's overall deductible \$128
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$128
Copayments	\$0
Coinsurance	\$180
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$308</b>



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at <http://www.healthcare.gov/sbc-glossary> or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not Applicable.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,500 Individual / \$3,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , and health care services this <a href="#">plan</a> doesn't cover, indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes, but you may self-refer to certain <a href="#">specialists</a> .	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$20 / visit	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs	\$10 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines. No Charge for Contraceptives, <a href="#">deductible</a> does not apply.
	Preferred brand drugs	\$30 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines. No Charge for Contraceptives, <a href="#">deductible</a> does not apply.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> up to \$150 / prescription	Not Covered	Up to a 30-day supply retail. Subject to <a href="#">formulary</a> guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$20 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 / visit	\$50 / visit	None
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	None
	<a href="#">Urgent care</a>	\$20 / visit	\$20 / visit	Non- <a href="#">Plan providers</a> covered when temporarily outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Mental / Behavioral Health:</b> \$20 / individual visit. No Charge for other outpatient services; <b>Substance Abuse:</b> \$20 / individual visit. \$5 / day for other outpatient services	Not Covered	Mental / Behavioral health: \$10 / group visit; Substance Abuse: \$5 / group visit
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	None
If you need help recovering or have other special health	<a href="#">Home health care</a>	No Charge	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
needs	<a href="#">Rehabilitation services</a>	Inpatient: No Charge Outpatient: \$20 / visit	Not Covered	None
	<a href="#">Habilitation services</a>	\$20 / visit	Not Covered	None
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	Up to 100 days maximum / benefit period
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	Subject to <a href="#">formulary</a> guidelines. Requires prior authorization.
	<a href="#">Hospice services</a>	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	None
	Children's glasses	Amounts in excess of \$125 allowance	Not Covered	Allowance limited to once every 24 months.
	Children's dental check-up	Not Covered	Not Covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Children's glasses</li> <li>• Cosmetic surgery</li> <li>• Dental Care (Adult &amp; Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (Plan provider referred)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (30 visit limit / year)</li> <li>• Hearing aids (\$2500 limit /ear every 36 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul>

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

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

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

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

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

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

**Language Access Services:**

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

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

Chinese (中文): 如果需要中文的帮助, ☎☎打☎个号☎1-800-757-7585 (TTY: 711)

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

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



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

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$0
- Other (blood work) [copayment](#) \$0

This EXAMPLE event includes services like:  
Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$90</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$0
- Other (blood work) [copayment](#) \$0

This EXAMPLE event includes services like:  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Joe would pay is</b>	<b>\$1,050</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$0
- Other (x-ray) [copayment](#) \$0

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$200</b>

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