CARPENTER FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA, INC.

carpenterfunds.com

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July 2025

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 so the Plan is not allowed to customize much of the form or content. The attached SBC includes:

- A health plan comparison tool called "Coverage Examples." These examples illustrate how the medical plan covers care for three common health scenarios: having a baby, diabetes care and care for a fractured bone. These examples show the projected total costs associated with each of these three 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.

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(s) of 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 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 or call 1-888-547-2054 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Contract Provider: $128/individual per calendar year; $256/family per calendar year. Non-Contract Provider: $257/person per calendar year; $514/family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this Plan begins to pay. If you have other family members on the Plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Mental health, chemical dependency (including detox), member assistance program visits, Contract Provider On-line physician visits up to $49 per visit, and outpatient prescription drugs are covered before you meet your deductible.	This Plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this Plan?	There is no out-of-pocket limit on all types of cost sharing, but there is a $1,289/person ($2,578/family) on the amount of coinsurance that you must pay for covered services in a year.	This Plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, hearing examination and hearing aid expenses, penalties for failure to obtain pre-certification, deductibles, expenses from Non-Contract providers, outpatient retail/mail order prescription drug expenses, amounts over the reference-based pricing allowances, and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward your out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-888-547-2054 for a list of Contract providers in California. See www.bcbs.com or call 1-800-810-2583 for a list of Contract providers outside the state of California.	This Plan uses a provider network. You will pay less if you use a provider in the Plan's network. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	• Services from Non-Contract providers not registered with CMS are limited to $200/appointment. • Plan pays 100% for physician online visits with a Contract provider.
	Specialist visit	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $200/appointment.
	Preventive care/screening/ Immunization	10% coinsurance	30% coinsurance	• For adults and children, benefits are limited to one routine physical exam in any 12-month period. • 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. • No charge for COVID-19 vaccine and deductible does not apply from a Contract provider. No coverage from a Non-Contract provider. • 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. • Services from Non-Contract providers not registered with CMS are limited to $200/appointment.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Professional/physician charges may be billed separately (Services from Non-Contract providers not registered with CMS are limited to $200/appointment). Pre-certification is required for CT/CTA, MRI, Nuclear Cardiology, PET Scans, and Echocardiography.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or call 1-800-939-7093.	Generic drugs	Retail: $15 copay/fill; Mail order: $26 copay/fill	You pay 100% (unless there are no network pharmacies within 10 miles). Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy	• Retail Pharmacy – 30-day supply. • Mail Order Pharmacy – 90-day supply. • Deductible does not apply to outpatient prescription drugs. • Cost sharing for outpatient prescription drugs **does not count** toward your out-of-pocket limit. • If the cost of the drug is less than the copay, you pay just the drug cost. • Some prescription drugs are subject to preauthorization (to avoid non-payment), or step therapy requirements. • Brand name Proton Pump Inhibitors (PPI) and Cholesterol drugs not covered. • For any new Brand Name Drug approved by the federal FDA, including injectable and infusion drugs, the copay 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 copay will remain at 50% of the cost of the drug. • Mail Order is mandatory if more than 2 prescriptions are filled for maintenance medications.
	Preferred brand drugs (Formulary brand drugs)	Retail: $15 copay/fill + cost difference between generic and brand for multi-source brand. $53 copay/fill for single-source formulary brand. Mail order: $26 copay/fill + cost difference between generic and brand for multi-source brand. $106 copay/fill for single-source formulary brand.		
	Non-preferred brand drugs (Non-formulary brand drugs)	Retail: $80 copay/fill; Mail Order: $133 copay/fill		
	Specialty drugs	Subject to Retail Copays (30-day supply).	Not covered	Specialty drugs are available only from the PBM's Mail Order Pharmacy (except certain emergency drugs may be provided by a retail Participating Pharmacy).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance plus any amounts over $300	For certain outpatient 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, pre-certification is required for outpatient surgeries.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $200/appointment.

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	Emergency room care	***Medical:*** 10% coinsurance; ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 30% coinsurance (10% coinsurance if no choice in hospital due to emergency); ***Mental Health or Substance Abuse:*** No charge	Professional/physician charges may be billed separately. (Services from Non-Contract providers not registered with CMS are limited to $200/appointment).
	Emergency medical transportation	10% coinsurance	10% coinsurance.	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.
	Urgent care	***Medical:*** 10% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 30% coinsurance (10% coinsurance if no choice in hospital due to emergency); ***Mental Health or Substance Abuse:*** No charge	Services from Non-Contract providers not registered with CMS are limited to $200/appointment.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	• Pre-certification is required. • A maximum of $35,000 is payable for the hospital facility charges associated with a single hip joint or knee joint replacement surgery. • In a Non-Contract Hospital, the Plan 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). • Services from Non-Contract providers not registered with CMS are not covered.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.

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	***Mental Health:*** 10% coinsurance; ***Substance Abuse:*** no charge, deductible does not apply	30% coinsurance	• Plan pays 100% for online physician visits with a Contract Provider. • Services from Non-Contract providers not registered with CMS are limited to $200/appointment.
	Inpatient services	***Mental Health:*** 20% coinsurance, deductible does not apply; ***Substance Abuse:*** no charge, deductible does not apply, for first rehab program, 10% coinsurance for subsequent programs.	30% coinsurance	• Pre-certification is required. • In a Non-Contract Hospital, the Plan 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). • Services from Non-Contract providers not registered with CMS are not covered.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	• Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). • Services from Non-Contract providers not registered with CMS are limited to $200/appointment
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Pre-certification 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	Home health care	10% coinsurance	30% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $200/appointment.
	Rehabilitation services	10% coinsurance	30% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $200/appointment. ***Inpatient:*** Services from Non-Contract providers not registered with CMS are not covered.
	Habilitation services	Therapy done as part of an approved autism plan: 10% coinsurance; Other services: Not covered	Not covered	Coverage is limited to therapy that is being done as part of an approved autism plan.

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)	
	Skilled nursing care	10% coinsurance	30% coinsurance	Pre-certification is recommended. Limited to 70 days per confinement. Services from Non-Contract providers not registered with CMS are not covered.
	Durable medical equipment	10% coinsurance	30% coinsurance	Rental covered up to reasonable purchase price.
	Hospice services	10% coinsurance	30% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $200/appointment. ***Inpatient:*** Services from Non-Contract providers not registered with CMS are not covered unless terminally ill. Respite care is limited to 8 days.
If your child needs dental or eye care	Children's eye exam	$10 copayment/exam	$10 copayment/exam	Vision benefits are available through a separate vision plan. Your cost sharing pertaining to vision plan services does not count toward this medical Plan's out-of-pocket limit.
	Children's glasses	$25 copayment, plus all amounts over $175 for frames	$25 copayment, 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. Your cost sharing pertaining to Voluntary Dental Plan services does not count toward this medical Plan's out-of-pocket limit.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Habilitation services (except for therapy that is being done as part of an approved autism plan)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (up to $35/visit and 20 visits per calendar year)
- Bariatric surgery (with pre-certification)
- Chiropractic care (Employee and spouse only. Up to $25/visit up to 20 visits per calendar year)
- Dental care (Adult) (except under a Voluntary Dental Plan)
- Hearing aids (limited to $800/ear in any 3-year period)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (under separate vision plan)
- Routine foot care

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. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

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

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

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

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

Language Access Services:

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

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.

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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$128
Copayments	$60
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$1,458

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$128
Copayments	$330
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$678

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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$128
Copayments	$10
Coinsurance	$270
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$408

KAISER PERMANENTE® : TRADITIONAL PLAN

Coverage for: Individual/Family | Plan Type: HMO

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

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

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

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not Covered	None
	Specialist visit	$20 / visit	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	$10 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs (Tier 2)	$30 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Non-preferred brand drugs (Tier 2)	$30 / prescription	Not Covered	The cost sharing for non-preferred brand drugs under this plan aligns with the cost sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	20% coinsurance up to $150 / prescription	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	$50 / visit	$50 / visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$20 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: $20 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / individual visit. No Charge 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 copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	None. Requires prior authorization.
	Rehabilitation services	Inpatient: No Charge; Outpatient: $20 / visit	Not Covered	None
	Habilitation services	$20 / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	100 day limit / benefit period.
	Durable medical equipment	No Charge	Not Covered	Requires prior authorization.
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam	Not Covered	None
	Children's glasses	No Charge	Not Covered	Up to $150 frames & lenses / 24 months, or up to $150 contact lenses (instead of glasses) / 12 months.
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental Care (Adult & Child)
- Home health care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (plan provider referred)
- Bariatric surgery
- Chiropractic care (30 visit limit / year)
- Hearing aids ($2500 limit / ear every 36 months)
- Infertility treatment
- Routine eye care (Adult)

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

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

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

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

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

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

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$60**

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*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

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*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

The plan would be responsible for the other costs of these EXAMPLE covered services.