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 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 $6,445/person ($12,890/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 precertification, 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 the 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	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

Important Questions	Answers	Why This Matters:
	call 1-800-810-2583 for a list of Contract providers outside the state of California.	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	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Specialist visit	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Preventive care/screening/ Immunization	20% coinsurance	40% coinsurance	• For adults and children between ages 2 and 18, benefits are limited to one routine physical exam in any 12-month period. • 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 $100/appointment.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	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)	20% coinsurance	40% 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 the out-of-pocket limit. • If the cost of the drug is less than the copay, you pay just the drug cost. • 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)	20% coinsurance	40% coinsurance plus any amounts over $300	For the hospital facility charge, a maximum of $6,000 is payable for an arthroscopy, $2,000 for cataract surgery, $1,500 for colonoscopy, and $1,000 for endoscopy. Precertification is recommended for outpatient surgery.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/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:*** 20% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 40% coinsurance (20% 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 $100/appointment).
	Emergency medical transportation	20% coinsurance	20% 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:*** 20% coinsurance. ***Mental Health or Substance Abuse:*** No charge	***Medical:*** 40% coinsurance (20% 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 $100/appointment.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	• Precertification is required. • A maximum of $30,000 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	20% coinsurance	40% 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:*** Office visit: No charge, deductible does not apply. Other outpatient services: 20% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply	40% coinsurance, deductible does not apply.	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Inpatient services	***Mental Health:*** 20% coinsurance, deductible does not apply. ***Substance Abuse:*** no charge, deductible does not apply.	40% coinsurance, deductible does not apply.	• Precertification 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	20% coinsurance	40% coinsurance	• Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). • Services from Non-Contract providers not registered with CMS are limited to $100/appointment
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are not covered.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	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	Home health care	20% coinsurance	40% coinsurance	Services from Non-Contract providers not registered with CMS are limited to $100/appointment.
	Rehabilitation services	20% coinsurance	40% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $100/appointment. ***Inpatient:*** Services from Non-Contract providers not registered with CMS are not covered.
	Habilitation services	Not covered	Not covered	You pay 100% for this service, even in-network.
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification is recommended. Limited to 70 days per confinement. Services from Non-Contract providers not

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)	
				registered with CMS are not covered.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental covered up to reasonable purchase price.
	Hospice services	20% coinsurance	40% coinsurance	***Outpatient:*** Services from Non-Contract providers not registered with CMS are limited to $100/appointment. ***Inpatient:*** 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 copayment	$10 copayment	Vision benefits are available through a separate vision plan. Your cost sharing does not count toward the medical plan's out-of-pocket limit.
	Children's glasses	$25 copayment, plus all amounts over $150 for frames	$25 copayment, plus all amounts over $35 for single vision lenses and amount over $45 for frames	
	Children's dental check-up	No charge, a deductible does not apply to these services.		Limited to $2,500/person for Contract and $2,000/person for Non-Contract per calendar year. Dental benefits are available through a separate dental plan. Your cost sharing does not count toward the 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
- 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 precertification)
- Chiropractic care (Employee and spouse only. Up to $25/visit up to 20 visits per calendar year)
- Dental care (Adult) (up to $2,500 for Contract and $2,000 for Non-Contract per calendar year)
- 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 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**

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，**请拨打这个号码** 1-888-547-2054.

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

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$128
Copayments	$90
Coinsurance	$2,490
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$2,718

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$128
Copayments	$580
Coinsurance	$570
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,338

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$128
Copayments	$0
Coinsurance	$360
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$488**

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 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 https://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.
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 providers 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	Services related to infertility covered at $20 / visit.
	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 you need 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

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 drugs to treat your illness or condition **More information about prescription drug coverage is available at www.kp.org/formulary.**	Generic drugs	Plan pharmacy: $10 / prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	Plan pharmacy: $30 / prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	30% coinsurance / prescription up to $150 maximum for 1 to 30 days	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
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
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$20 / visit	$20 / visit	Non-Plan providers covered when outside the service area.

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 have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral Health: $20 / individual visit. No Charge for other outpatient services; Substance Abuse: $20 / individual visit. $5 / day for other outpatient services	Not Covered	Mental / Behavioral Health: $10 / group visit; Substance Abuse: $5 / group visit.
	Inpatient services	$250 / admission	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	$250 / admission	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum / visit, up to 3 visits maximum / day, up to 100 visits maximum / year.
	Rehabilitation services	Inpatient: $250 / admission; Outpatient: $20 / visit	Not Covered	None
	Habilitation services	$20 / visit	Not Covered	None
	Skilled nursing care	$250 / admission	Not Covered	Up to 100 days maximum / benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	None
	Children's glasses	Amount in excess of a $125 allowance	Not Covered	Allowance limited to once every 24 months. You may have other optical coverage not described here. Refer to "Other Covered Services" for additional information.
	Children's dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

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) • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot care unless medically necessary • 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 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 agency in the chart below. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care and Department of Insurance at 980 9th St, Suite #500 Sacramento, CA 95814, 1-888-466-2219 or http://www.HealthHelp.ca.gov.

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

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

Does this plan provide Minimum Essential Coverage? Yes

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，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	$250
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copays	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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	$250
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copays	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$1,050**

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	$250
Other (x-ray) copayment	$0

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

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copays	$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