
 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 <u>deductible</u>?	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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Mental health, chemical dependency (including detox), member assistance program visits, Contract <u>Provider</u> On-line physician visits up to \$49 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.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	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.
What is not included in the <u>out-of-pocket limit</u>?	<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 www.anthem.com/ca or call 1-888-547-2054 for a list of Contract <u>providers</u> in California. See www.bcbs.com 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"> Services from Non-Contract providers not registered with CMS are limited to \$100/appointment. Plan pays 100% for physician online visits with a Contract provider.
	<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"> 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	<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.

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>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.</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"> • Retail Pharmacy – 30-day supply • Mail Order Pharmacy – 90-day supply • <u>Deductible</u> does not apply to outpatient <u>prescription drugs</u>. • <u>Cost sharing</u> for outpatient <u>prescription drugs</u> does not count toward the <u>out-of-pocket limit</u>. • If the cost of the drug is less than the <u>copay</u>, 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 <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. • Mail Order is mandatory if more than 2 prescriptions are filled for maintenance medications.
	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).	Not covered	
<p>If you have outpatient surgery</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 recommended 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.

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>	<i>Medical:</i> 10% <u>coinsurance</u> . <i>Mental Health or Substance Abuse:</i> No charge	<i>Medical:</i> 30% coinsurance (10% coinsurance if no choice in hospital due to emergency). <i>Mental Health or Substance Abuse:</i> 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>	<i>Medical:</i> 10% <u>coinsurance</u> . <i>Mental Health or Substance Abuse:</i> No charge	<i>Medical:</i> 30% coinsurance (10% coinsurance if no choice in hospital due to emergency). <i>Mental Health or Substance Abuse:</i> 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"> • 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 <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). • Services from Non-Contract providers not registered with CMS are not covered.
	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.

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% <u>coinsurance</u>	<ul style="list-style-type: none"> Plan pays 100% for physician online visits with a Contract Provider. 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, for first rehab program, 10% <u>coinsurance</u> for subsequent programs.	30% <u>coinsurance</u>	<ul style="list-style-type: none"> Precertification is required. 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) Services from Non-Contract providers not registered with CMS are not covered.
If you are pregnant	Office visits(10% <u>coinsurance</u>	30% <u>coinsurance</u>	<ul style="list-style-type: none"> 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	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>	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.
	<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</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.

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>equipment</u>			
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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 <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 \$150 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 excluded services.)

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|--------------------------------|-------------------------|------------------------|
| • Cosmetic surgery | • Infertility treatment | • Private-duty nursing |
| • <u>Habilitation services</u> | • Long-term care | • Weight loss programs |

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

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

* For more information about limitations and exceptions, see the plan or policy document at 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. 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
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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
The total Peg would pay is	\$1,468

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
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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
The total Joe would pay is	\$1,058

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
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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
The total Mia would pay is	\$308

 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 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 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	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 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
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	\$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	\$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	Same as preferred brand drugs	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	20% coinsurance up to \$150 / prescription	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines. Infertility and sexual dysfunction Specialty drugs you pay 50% coinsurance.

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 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	\$50 / visit	\$50 / visit	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	\$20 / visit	\$20 / visit	Non- Plan provider s 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 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	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 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
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: No Charge; Outpatient: \$20 / visit	Not Covered	None
	Habilitation services	\$20 / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	Up to 100 days maximum / benefit period.
	Durable medical equipment	No Charge	Not Covered	Subject to formulary guidelines. Requires prior authorization.
	Hospice service	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	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 .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Acupuncture (plan provider referred) • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care (30 visit limit / year) • Hearing aids (\$2500 limit / ear every 36 months) 	<ul style="list-style-type: none"> • 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, 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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
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<ul style="list-style-type: none"> ■ The plan's overall deductible \$0 ■ Specialist copayment \$20 ■ Hospital (facility) copayment \$0 ■ Other (blood work) copayment \$0 	<ul style="list-style-type: none"> ■ The plan's overall deductible \$0 ■ Specialist copayment \$20 ■ Hospital (facility) copayment \$0 ■ Other (blood work) copayment \$0 	<ul style="list-style-type: none"> ■ The plan's overall deductible \$0 ■ Specialist copayment \$20 ■ Hospital (facility) copayment \$0 ■ Other (x-ray) copayment \$0
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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*)

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*)

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	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copays	\$30	Copays	\$1,000	Copays	\$200
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$50	Limits or exclusions	\$0
The total Peg would pay is	\$90	The total Joe would pay is	\$1,050	The total Mia would pay is	\$200

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